Book 06

PUBLIC HEALTH RESOURCE NETWORK

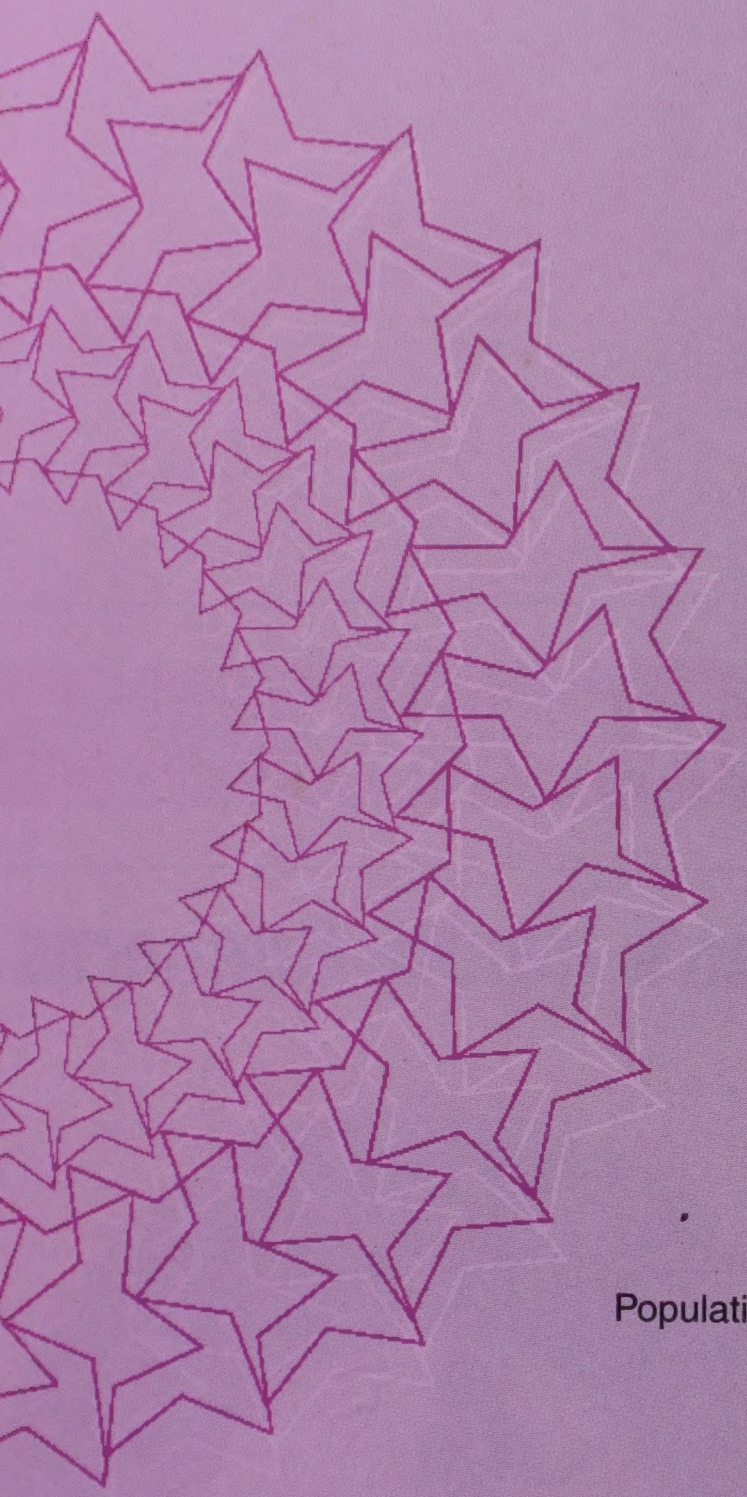
Mainstreaming Women's Health Concerns

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

Book 6

Public Health Resource Network

Mainstreaming Women's Health Concerns



Coordinating Agency

State Health Resource Centre, Chhattisgarh

Partners

National Rural Health Mission

National Institute of Health and Family Welfare

Department of Health & Family Welfare, Chhattisgarh

State Institute of Health & Family Welfare, Chhattisgarh

Jharkhand Health Society

Institute of Public Health, Jharkhand

State Institute of Health & Family Welfare, Orissa

Population Foundation of India (Regional Resource Centre for RCH)

Child in Need Institute

ICICI Centre for Child Health and Nutrition

Design and Layout

Mishta Roy

Ajay Shah

Printing

Surya Offset Printers (I) Pvt. Ltd., Raipur

First Edition: February 2007

Contents

Preface

The National Rural Health Mission's vision of a national programme planned at the district level, and if possible at the village level, needs an exponential increase in capacities at all levels. The NRHM has initiated many steps in this direction. However the nation is vast and diverse. And there are many constraints in existing planning and implementing structures that would need to be overcome. This calls for the official national mission-led process to be supplemented with many varied, creative and massive endeavours at capacity building. State governments, health resource centers, different professional sections and different sections of civil society all need to contribute to meeting these enormous needs of capacity building.

This initiative called the Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantees of increased employment or career options. It is meant to support individuals and organisations both within and outside the Health Department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out of information, tools and a diversity of programme options and perspectives.

The course faculty and editors of the modules are drawn up exclusively from those who have been active in various states in providing support to governments and non-governmental organisations in health and related sectors. This programme itself is being organised primarily by a number of agencies

already providing resource support to states on different aspects of NRHM programmes.

A Mission needs Missionaries, and it needs them where the challenges are greatest - in the remote and most underdeveloped areas of the northern and eastern states, and indeed in all the under-served areas of all the states. A Health Mission needs these missionaries to also be professionals, where being a professional is not one more form of privilege- but a competence that anyone willing to put in the time and effort — and a little expense — can acquire! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change, and of those who work in the health sector because they seek to work for the poor. The true test of the programme is thus not the number of certificates that we issue but the better quality of district plans, a higher motivation of district teams and eventually better health outcomes in the district. The immediate context is the National Rural Health Mission. And hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralised planning and decentralised governance and to all societal efforts towards an equitable and just society.

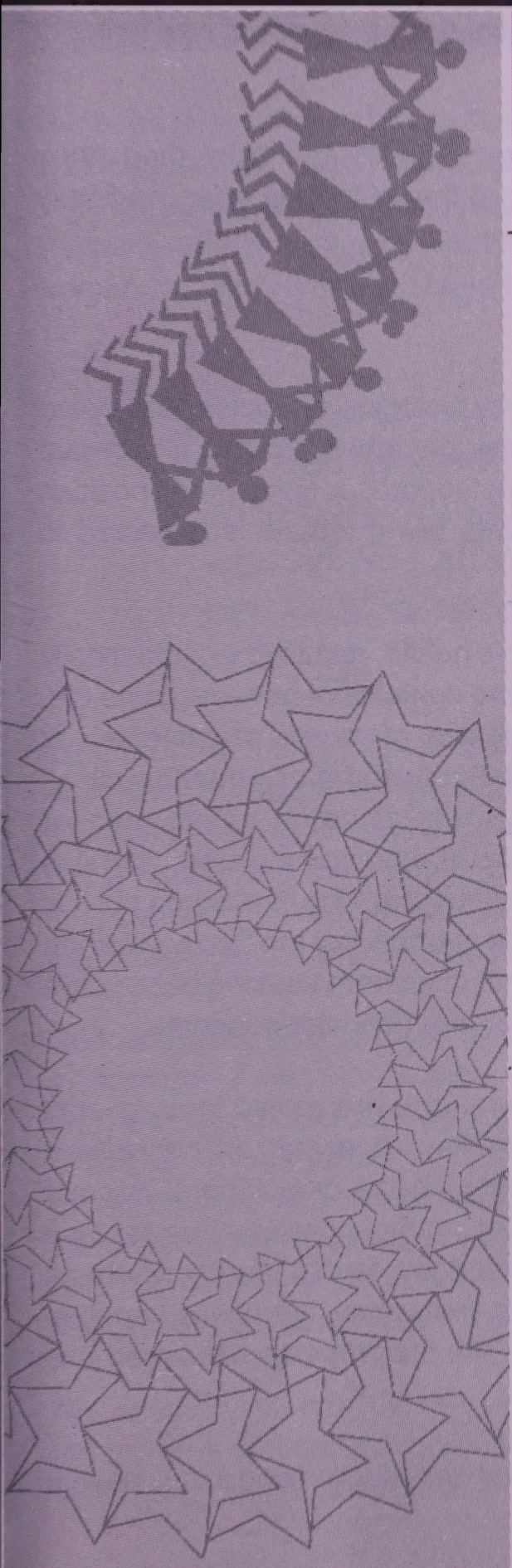
In this book, the sixth volume of the PHRN series, we have three distinct sections. In the first section we discuss a number of areas related to women's health that usually get inadequate emphasis. We note however that in many of these areas the advice is very tentative, for despite considerable advances in theoretical understandings there are almost no district level programmes to quote as best practices. We then go on to discuss what has traditionally been the central concern of health planning – population stabilisation – and discuss the problems at the level of theory and at the level of operations which have led to what we consider a supply side crisis in the provision of contraceptive services. Finally we close with a tentative overview of the area of adolescent health, an area where both theory and practice remain at an early stage of development.

These books are written based on a synthesis of theory from academic public health with experience from district level public health practitioners. Many of the latter have no formal training on public health, but nevertheless are repositories of much public health knowledge. We need to continue this process inspired by a much more democratic vision of how knowledge is created. The PHRN looks forward therefore to an active process of feedback and interactions that leads to future editions that are even more enriched by district level experience.

Dr. T. Sundararaman
PHRN Programme Coordinator

Lesson ONE

Patriarchy, Gender and the Health of Women



In this lesson we shall discuss:

- Meaning of the word 'gender' as different from sex.
- Impact of patriarchy and gender on health.
- Various mechanisms through which gender impacts health.
- Various ways in which decision making in the health sector gets "engendered".
- The necessity and processes of constructing women's health action as a part of the larger quest for gender equity.

SEX AND GENDER

'Sex' is the *biological* fact of being male or female whereas 'gender' is a *social construct* that refers to the economic, social and cultural consequences, opportunities and discriminations associated with being of a particular sex.

Biologically speaking, women only have a few health attributes that are different from men: they menstruate, they bear children, they are not responsible for the sex of the child they bear, and they have the ability to breast feed.

SEX AND DISEASE VERSUS GENDER AND DISEASE

In terms of morbidity and disease also, certain situations are determined by biological attributes associated with being female such as greater predisposition to anemia, greater risk of certain cancers like breast cancer, greater risk of being affected by STDs, higher risk of developing osteoporosis, lower predisposition to heart disease at young age etc. On the whole, biologically speaking, being female is expected to confer a more hardy health status as compared to males.

However it is not sex, but gender that has a far greater impact on women's health, resulting in a drastically poorer status of health of women compared to men, even within the same contexts of poverty, caste etc. The most telling statistic of the poor situation of women in a social context is, of course, an adverse sex ratio and the underlying phenomena of female feticide and infanticide. Many situations of ill health such as mental illness, physical abuse, malnutrition etc may be related to gender alone. In others, gender exacerbates biological vulnerability. For example, women may be prone to anemia by biology, but it is gender that makes them eat little, at the last and poorer quality food. Women give birth to children but it is gender that makes them the prime caregivers of children, elderly and sick members of the family. Women may have a greater risk of contracting STDs, but it is gender that prevents them from seeking health care or speaking openly about sexual matters or being able to insist that their partners use condoms.

The impact of gender upon women's health are severe and well known, and are rooted in an overall system of discrimination, general devaluation and neglect of women in a society where men are considered superior – the social system of 'patriarchy'. The social system of patriarchy has a beginning. It was not present in all societies at all times. And it will have an end. Even today many societies have far less gender inequity than we have in India today. Patriarchy was closely related to a feudal society where all inequalities were considered "natural" and determined by birth. Women were considered less capable. They were even considered less like individual human beings and more like the property of the men – to be manipulated according to the "male" needs of society.

The main need of women for the male came to be seen as related to sex and reproduction and to housework

and child-rearing. Though her role in child bearing and child care is indeed natural – the failure to see the male role in child care, and the failure to recognise that other than this she has an equal right to develop her talents and to take part in all decision making, be it in the family or in society, has nothing natural about it. It was a creation of patriarchy.

Our society is no longer feudal. It no longer states that birth determines privilege and status. It is supposed to be based on equality of opportunity and merit. However in practice, even in today's society birth determines one's status and one's opportunities to a large extent. And today we study patriarchy and gender to understand the various mechanisms by which there continues to be so much inequality for women and injustice against women in a society which states equality and justice as basic constitutional values.

> *The roles of a woman in child bearing and child care are naturally well-recognised, but the failure to recognise the male role in child care or the failure to recognise that in addition to these, a woman has an equal right to develop her talents and to take part in all decision-making, has nothing natural about it!*

In particular in the field of health we need to understand why being born a woman makes for a much higher likelihood of disease or death up to the age of 30. Further we need to understand why most doctors, especially in the government system are men, whereas almost all nurses are women. Why the Sub-center had a female and male worker but now largely has only female workers. Or why health system gives so much attention to reproductive health and not to mental health even though suicides kill far more women than child-birth. Or why in most hospitals there are fewer beds for women and fewer toilets.

Gender should also be understood as a product of the relationships between men and women, as well as an attribute of men per se. Men benefit from but also 'suffer' social and cultural constructs of 'manliness' and how men should behave. For example, they are also expected to shoulder the economic responsibility of the family and failure to do so leads to tremendous loss of self-esteem - which in turn becomes a problem for earning women who are supporting husbands. (Though often women are also earning and this invisible role does not even get acknowledged.) In family life, what they gain in power and domination over women, they lose many times over in terms of companionship and support and indeed in the happiness and pleasure of life itself.

Nor should patriarchy be seen as merely the physical oppression of men by women. Patriarchy defines life patterns and culture, and even the way men and women think about one another. This includes the way women think about themselves and about other women. Older women treat younger women who

come into their houses on marriage and depend on them with a sense of domination and as their property to do as they wish with them – this is all too well known. (The worst form of it is bride burning. And burns are one of the commonest causes of deaths in the 15 to 45 age group). Mothers bring their daughters up to accept patriarchy rather than fight it. However, it should be recognised that even as these dominant women are women themselves, they are a part of the patriarchal system of domination. They also have to derive their power from maintaining their relationship with a man – be it husband or son. Patriarchy as a culture also means that women internalise notions of submission and suffering in silence as desirable norms of behaviour. They deny their own sexuality and learn to be ashamed of their own bodies. All these have considerable implications for making a health plan that is committed to redressing gender equity.

> *Patriarchy should not be seen as merely the physical oppression of men by women. Patriarchy defines life patterns and culture and even the way men and women think about each other.*

If gender is a social construct whose present meaning can be changed, the change will undoubtedly have consequences for men too. Gender differences would remain – for not all of them are oppressive. There are many that are desirable and make society richer. But gender would no longer be equated with discrimination which is the context of all that is engendered today. This would mean many changes in the roles that have become stereotyped as the natural roles of each sex. If, for example, women have to be freed from the burden of doing all the housework and childcare, men will have to contribute more. However, it is largely understood that the impetus for change must come from the group that faces the greater disadvantage, the group that is discriminated against – in this case, women – and this has implications for gender mainstreaming strategies as we shall see later, *in lesson 2*. Thus, in the current context of patriarchy, gender has come to imply a focus on all inequalities and discriminations faced by women.

How Does Gender Discrimination Impact Women's Health?

1. *Poverty* – Women's control over economic resources is far less than that of men. They are paid less for wage work, not paid at all for housework, inherit less property and have little or no control over family finances. Even within poor households, women eat less and suffer more stress to make ends meet somehow.

2. *Work* – The work load of women, especially poor women, is far higher than men. Referred to as their 'triple burden', women undertake housework, wage work and child care. The management of food and water for the family alone contributes to a huge workload for women and young girls. 4-5 hours of the day and much physical labour may go in arranging a day's supply of water for the

family. According to the WHO, the poor quality of water and poor sanitation causes about 80% of all sickness in the world, which makes huge demands upon the woman as the main care giver. Thus, an engendered policy for provision of safe water can be a very significant intervention in women's health and the reduction of their poverty, and many case studies are available from India and its neighbours that demonstrate this point.[1] Similarly, a recognition of the fact that many if not most farmers are women, can lead to policies that are more protective of their health and rights as workers.[2] More than 90% of working women do so in the informal sector where social security arrangements such as maternity entitlements are completely absent. Women draw lesser wages for equal work and are rarely to be seen in positions of power and decision making. The division of work is also such that their health is often at risk – from the smoke of chullahs, from pesticides in agriculture and from the specific occupational hazards of work traditionally thought to be 'women's work' such as the fine work in electronic assemblies and textile industry.

3. *Nutrition* – Women traditionally eat after the whole family is fed. General low self esteem prevents them from demanding equal portions of food, specially if there is a dearth of food in the first place. Girl children may be breast fed less as well as given less and poorer quality food to eat. Not only is their own health and nutrition compromised, the intergenerational impact of this on the birth weight of subsequently born children is devastating.

4. *Culture* – The overall predominant image of a woman as mother and housewife debars her from educational and occupational opportunities and further compounds her economic and social disadvantage. Many cultural beliefs and practices are debilitating for women. Many of these pertain to the notion that women's sexuality is a shameful thing that requires the protection of men – either father or husband, or that her body is property in the care of her male 'guardian'. Thus, adolescent girls are withdrawn from school and married off as soon as they acquire puberty, they are prevented from eating 'hot foods' such as eggs, they are considered 'unclean' during menstruation and not allowed to participate in religious rites etc. This notion of women's sexuality as something she has to be ashamed of deprives her of the ability to negotiate for safer sexual relationships within or outside of marriage. The lack of bargaining power and the pervasive sense of their own 'shame' and 'family honour' also leaves them vulnerable to physical and sexual abuse- especially when it comes to resisting or protesting any abuse. Since a woman's 'chastity' is the symbol of family honour, honour killings and honour rapes are common expressions of interfamilial, inter caste or inter religious strife. Apart from social violence, the woman frequently suffers domestic violence, violence within the general community (rape, sexual harassment etc) as well as violence within health care systems (forced sterilisation, forced abortion, prenatal sex selection, forced contraception, manhandling by health workers etc). In fact, violence against women is one of the major causes of mental and physical ill health amongst women.

---

1. See, for example, Ahmed, S. (ed.) (2005). Flowing upstream : empowering women through water management initiatives in India. (Environment and development series / Centre for Environment Education). New Delhi, India, Foundation Books India.
2. See, for example, Bina Agarwal, A Field Of One's Own: Gender and Land Rights in South Asia (Cambridge University Press, 1994), the work of Deccan Development Society (DDS) and the Karnataka People's Forum for Land Rights (KPFLR), which was formed in 2001 to campaign for land reform.

WOMEN IN THE HEALTH SECTOR

Though the mortality and morbidity resulting from women's ill health is a cause of great concern, its roots in fundamental human rights violations is poorly accepted or acknowledged in the health sector.

1. **Women in health policy and programmes:** Reproductive health is one of the largest focus areas of the health sector in current years. Though there is a strong focus on women's health in the form of 'reproductive health', it is mostly seen as a way of improving the 'health of society' rather than a redressal of a gross injustice to women per se. Though it is a big need of women to have good quality reproductive health services, if these are not set within an overall understanding and sensitivity towards gender discrimination and women's rights, they tend to reinforce the notion of women as mothers and undermine the focus required for other types of morbidity such as infectious diseases and cancer and the specific requirements of women in these areas. Even within the basket of reproductive health services, issues such as infertility and cervical cancer are neglected since they are not perceived to further the overall goal of population stabilisation or family welfare.

   It should be understood that most laws, policies and programmes for women's right to health are largely influenced by the preponderance of men in policy making roles and that their influence predominates again in health research and allocations of resources for health. Therefore, any attempt to change systems and policies must necessarily use strategies that ensure and enable the participation of women in decision making at that level. While engendering health policy is a difficult enough task, ensuring their conversion to programme is even more difficult, since there is a tendency for them to 'evaporate' before they ever become concrete; a phenomenon ascribed to the inherently patriarchal nature of bureaucracies.[3]

2. **Women as health workers:** Women not only form the largest focus for the health sector as clients, specially as pregnant women and mothers, but also the largest providers of healthcare services in the field as ANMs, AWWs and now ASHAs. Yet, their representation in decision making positions of authority remains very poor- even where it is made up of such a workforce. Thus no nurse can rise to be a

> The health sector can play a vital role in preventing violence against women, helping to identify abuse early, providing victims with the necessary treatment, and referring women to appropriate care. Health services must be places where women feel safe, are treated with respect, are not stigmatised, and where they can receive quality, informed support. A comprehensive health sector response to the problem is needed, in particular addressing the reluctance of abused women to seek help.
>
> *Source:* WHO Multi-country Study on Women's Health and Domestic Violence against Women, 2005

3. SH Longwe, The Evaporation of Policies for Women's Advancement, UN, 1995

director of nursing or even deputy director – and it is often a male doctor who is assigned to be in charge of nursing. This workforce of many lakhs of women is held responsible for achieving all the main targets of health care such as reductions of MMR and IMR, but hold the lowest paid jobs with the least social or job security or respect in the hierarchy of health functionaries.

CASE STUDY: CHANGING COMPOSITION OF THE HEALTH WORKER

Sub-centers in all states were designed to have a male worker and a female worker. Over time, the only effective worker was the female worker or the ANM. Male posts were often not filled and this was justified by the fact that the center supported only the female worker who had family planning related functions while the male worker who had none was not supported. The male worker came to be seen as tending to laze around, unionise and not work. In many states unwritten policy decisions were taken to declare this a dying cadre and stop recruitment of the male worker as policy. In some states, in a bid to do away with this cadre on the grounds of their ineffectiveness, the male workers were all promoted as supervisors over the women who, however, did not get promotion. Net result – ANMs in most Sub-centers are handling double the load of what they were intended to handle and supervised often by male workers who have little understanding of the work.

If we ask a male workers' representative whether the charge of poor work justifies their exclusion, they had this to say: *"there have been no training programmes for male workers for over 15 years. Our work is poorly defined and often only seen as carrying the equipment and escorting the women workers. There is very little supervision or monitoring of the work – though ANMs work gets considerable attention. When an ANM is promoted she is given six months of residential training. But when a male worker is promoted, he has no training at all. For a number of years there has been no recruitment of male workers and in most states male worker pre-service training institutions have been closed down so that it cannot start either".* If we look closer we find that from the nature of funding to the nature of monitoring the real problem is the loss of importance to all work except some aspects of care in pregnancy and to immunisation. We can see that it is not a question of men versus women- both men and women are having to face a burden- though of different sorts. It is a question of how decision making and policy is "gendered"

3. **Women in community-based intervention strategies:** In community participation strategies, there is a prioritisation of women for undertaking health care responsibilities. This tends to further increase women's workloads and reinforce their traditional roles as care givers, without addressing the issue of male responsibility in health issues. Women are considered repositories of health related skills and information in communities and perform many informal health care functions. However, though this is utilised, this is poorly acknowledged and rewarded.

4. **Women in health sector research:** Women are not consulted in the formulation of their health needs and priorities – it is considered that society (which is a patriarchal society) knows best. Often, data that is gathered as a basis for determining the status of health is not disaggregated by sex at all. Obviously, the patriarchal basis for health care policy, research and programme affects the

allocation of resources to women's health issues too. Some of the technical reasons for engendering the planning of health research, in the context of diseases, are given below:

DISEASES AND CONDITIONS

1. May affect men and women differently
2. May be unique to women or groups of women
3. May be more prevalent in women
4. May have different implications for women at different periods of their life cycle
5. May affect women more seriously
6. May have risk factors that are different for women
7. May have interventions that are different for women

5. **Women as health sector clients:** Services are notorious for being insensitive and often abusive to women. Facilities to maintain confidentiality and privacy are poor or even absent. Toilets that women can use are often missing. Many services such as abortion still require the authorisation of the husband or father. In programmes like sterilisation camps the approach has been so mechanical and target driven that it often overrides other ethical and humane concerns in dealing with poor and sick women.

On the demand side, families hesitate to invest or incur costs over girls and women and are known to delay seeking medical care for them. Given this bias, any significant user fee would probably exacerbate this phenomenon and further discourage women and girl children from accessing health care services.

The 'opportunity costs' for women to take the time out to access health care is also considered greater since the whole families system of care depends so much on her. Where services are far and timings are inconvenient, this factor is made more significant.

Women may not be allowed or may not have the confidence to travel alone to a health care center or be examined by a male doctor. A woman may also not be able to buy or take medicines or go for investigations or take sudden decisions (such as having an incision and drainage of an abcess done or getting admited) without 'permission'. Thus she becomes dependent upon the convenience and will of male members of the family.

In all, some principles to address promotion and protection of the health of women could be drawn up as follows:[4]

4. Adapted from Women's health and human rights, RJ Cook, WHO 1994

Health Status

- Health considerations are important to women at different stages of their life cycle.
- There is a need to determine the special impact upon women of routine health procedures and products.
- Importance needs to be given for improving research on women's health requirements.
- There is a need to consider women's health requirements and circumstances in the development of all research protocols (*note the difference between the last point and this one*).
- There is a need for basing health policies on the most up to date scientific and technological knowledge.

Health Service

- The importance of treating women with dignity and respect, including the provision of adequate information so that women can make informed choices on particular courses of management.
- The rights of women as patients including the right to privacy and confidentiality.

Conditions Affecting the Health and Well-being of Women

- The importance of ensuring a safe, healthy working environment.
- The importance of eliminating traditions and practices that have detrimental health consequences for women.
- The ability to identify and respond appropriately to women who live in abusive environments.

STRATEGIES AND INSTRUMENTS FOR CHANGE

The above discussion traces the way patriarchy and gender have impact on women's health and on health care systems. It follows that one cannot address women's health issues without addressing gender equity issues. A shift of power, control and resources to women on the whole thus becomes an essential pre-requisite and part of the processes by which women can alter their situation of health and which allows them to make a positive intervention in their own health and that of their 'sisters'. Working for women's health implies therefore working for gender equity in health and working for gender equity in health becomes part of the process for working for gender equity in all of society.

Thus, clearly, processes of mobilisation, and processes of women's empowerment through enhancement of their knowledge, skills and organisation, and indeed the spirit of resistance to injustice and social change, are the lifeblood of any large scale meaningful interventions for women's health. (see Book 7 for a description of some women's movements in India). Some of the case studies provided in earlier books, specially Book 2 and Book 3 illustrate how women's mobilisation and empowerment and organisation can be built into health care programmes at the level of the community. (for example, Arogya Iyakkam and its intervention in child health, see lesson 3 Book 3).

The participation of women in decision making at all levels is thus a critical factor in health intervention for women. Such women's participation is needed in the way cadres are structured and administrative appointments are made. It also occurs because women's organisations and men and women who have been working for women's rights are invited to be part of the decision making process. It also happens when women's movements and representative organisations, raise these issues in public debate and build up popular opinion for forcing a change. Some of the historical shifts of strategy in 'gendered policies' are discussed in subsequent lessons on gender mainstreaming and on population stabilisation.. These were changes that came about through a combination of such processes.

Other than in policy making, gender sensitivity and awareness needs to be increased at all levels within the health system. This ranges from the need to sensitise the husbands of women health workers towards better understanding of the demands of the job and better support to their wives. to ensuring that nurses have promotional avenues, to all health care providers being sensitised to the entire gamut of women's health needs – going far beyond the traditional male concerns of care in pregnancy and family planning.

I. Review Questions

1. What is the difference between sex and gender ?
2. What are the ways in which patriarchy adversely affects women's health?
3. How does patriarchy adversely effect men and how can women be perpetrators of patriarchy?
4. How is decision making in the public health system 'en-gendered"
5. What are the main approaches for achieving gender equity in health?

II. Application Questions:

1. To what extent can a basic social question like gender equity be addressed in something so limited as a district health plan?
2. What difference would the insights of this lesson make to a district health plan? In a district plan:
   a. How do we address issues of women's mobilisation and empowerment?
   b. How do we address issues of women's participation in decision making?
   c. How do we address the way the structure of the health system is engendered?
   d. How do we address the way the service delivery priorities are currently defined?

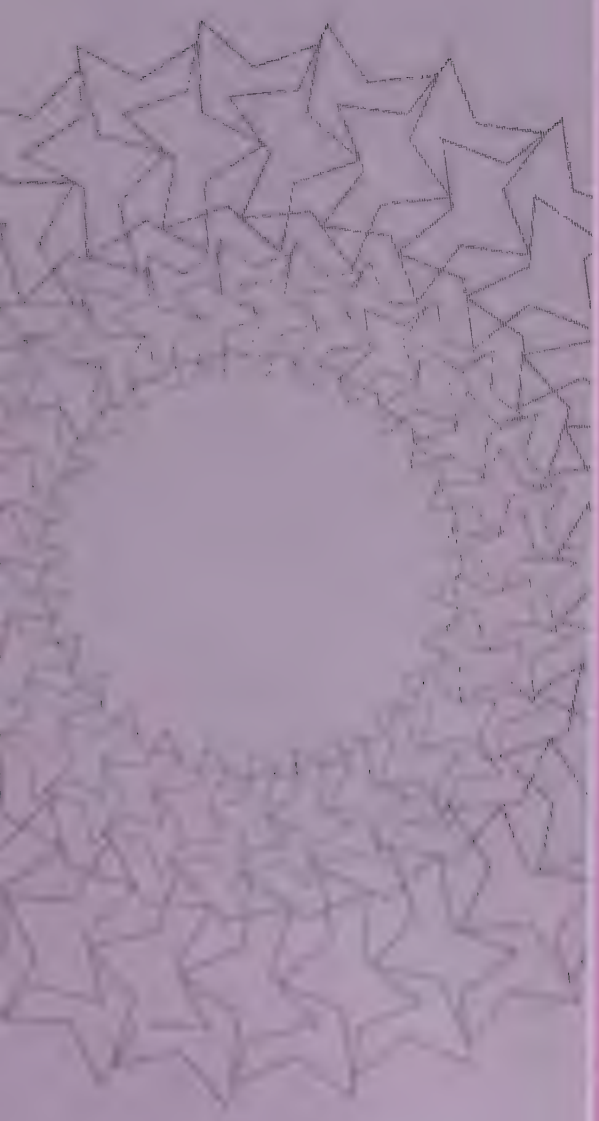
   Even if we can potentially do so – what are the obstacles to actually doing so?

III. Project Assignment

1. Document a process of ill health in a woman you are acquainted with from cause to treatment. Identify at every step, the way 'gender' has affected the process. (do take her permission to relate this case study!).
2. Look at your own or some other familiar organisation from the point of view of 'gender' what are your findings – both factual and descriptive?

Lesson TWO

Women in Development: Gender Analysis, Planning and Mainstreaming In Health Programming



In this lesson we shall discuss:

- The strategic shifts in the approach to women in development
- What gender analysis is and how to go about it; its components and levels
- What gender mainstreaming is and how to go about gender mainstreaming in health programmes
- What gender budgeting and gender component plans are
- What a health strategy with a gender perspective finally seeks to achieve

INTRODUCTION

In the previous lesson we discussed the influence of gender upon the health of women and the ways in which it acts. Women have been organising themselves and protesting discrimination in its various forms. Simultaneously, as there has been a growing awareness in society of the multiple forms that such discrimination takes, institutions, organisations and individuals concerned with 'development' and strategies of development have had to respond and address this discrimination in the area of health and indeed in all areas of development.

The strategies to address this discrimination are constantly evolving. These changes occur not only due to learnings from experience but are also responsive to the changing global thinking on 'development' on the whole. They also evolve with changing economic policies and public health systems and policy. We examine some of these strategic shifts below. This would help us to understand the different ways gender mainstreaming or 'gender planning' has been used and to choose the perspective with which we would like to work in a conscious manner. And it would help us understand what perspectives others are working with.

Approaches to Women in Development

Welfare
Equity
Anti-poverty
Empowerment

THE STRATEGIC SHIFTS IN THE APPROACH TO WOMEN IN DEVELOPMENT[1]

1. **The welfare approach** - Within the general concept of 'welfare' for vulnerable groups, women were recognised early on as being vulnerable. They were also recognised to be in charge of or responsible for other vulnerable people in the family and for being a source of cheap labour or 'voluntary work' in welfare work. This strategy was seen to be at work after the end of World War II in particular. This approach assumed that women were passive recipients of aid and development rather than active partners. It also focused largely on their roles in the family and their reproductive roles. However, by the 1970s there was widespread criticism of this approach from women professionals and activists which led to the development of alternative approaches as described below.

2. **The equity approach** – This was based on the analysis of economic processes and an understanding that modernisation and development did not necessarily result in more gender equality. There was a strong focus on women as contributors to the economy and an analysis of how the economic policies of the 1990s were having an adverse effect on women as workers. This approach identified the inequalities between men and women in the market place and how economic policies were reinforcing that inequality. In terms of correction, it promoted the idea of redistribution of economic

1. World Development, 17:11, Caroline Moser, 'Gender Planning n the Third World: Meeting Practical and Strategic Gender Needs', and Women in Development : A Framework for Project Analysis, DANIDA Manual, Tamil Nadu Area Health Care Project

assets from men to women regardless of class through positive discrimination policies if necessary.

As expected, this approach drew opposition from many different quarters. Many development aid agencies were concerned that advocating a change in 'power relations' was interfering too much with culture and tradition. Simultaneously, third world governments were wary of 'western influences' on their women. Third world activists also felt that fundamental issues of class and poverty were more important than gender equality in their context.

3. **The anti-poverty approach** – This was the compromise that resulted; women could be the focus of attention as the poorest of the poor, if not for reasons of positive discrimination. It continued to give priority to women's economic roles and their access to and control over assets and resources as a way of poverty alleviation as well as reducing gender discrimination. It has promoted strategies of income generation and vocational training to women to meet 'practical' gender needs rather than strategic ones. Interventions have remained small scale, often financially unsustainable and may have adverse impact on women's reproductive roles as their economic burden increases without redistribution of other responsibilities. Another variant of this approach was to focus only on development and removal of poverty on the assumption that with such development gender equity would automatically follow.

4. **The empowerment approach** – This has emerged due to the assertion of third world women's movements and democratic movements that have been fighting for equality. This approach emphasises the fact that women experience oppression differently in different contexts. It places the so-called feminisation of poverty (i.e. a disproportionate part of the poor are made up of women) as a consequence of 'top down' development policies themselves. It calls for the issues concerning women to be addressed as arising from gender as well as their social, economical and political contexts in an integrated manner. Thus, it challenges global, national and local power structures and insists that women have the right to make their own choices and practice them through control over critical resources in their own specific contexts. It denies that development only favours men and places less emphasis on extracting power from men (equity approach) and more on increasing the capacities and power of women per se. For example, women's movement activists in a country that is struggling against apartheid or colonial rule or civil war may have priorities that are quite different from activists of a 'developed' nation and they must be able to express their priorities in policies affecting them. The main strategy being used is that of organising women based on common practical needs to ultimately gain in terms of strategic needs rather than depend on top down legislative or policy changes. For example, women living in urban slums may consider a demand for adequate housing their first priority. This may (and has in actual fact) lead quickly to interventions in women's right to inherited property and larger debates on housing rights.

GENDER ANALYSIS

Gender-sensitivity is the awareness that most problems, situations and solutions have a gender dimension to them. Gender analysis is a way of 'seeing/analysing' problems, situations and solutions with an awareness of gender relations and in order to identify gender issues. This needs some training and practice and it should not be assumed that gender-sensitivity leads automatically or immediately to the ability to do gender analysis. This looking through 'gendered spectacles' should apply to all levels of planning as discussed below.

The key elements of a gender analysis should include:

1. Identification of similarities and differences (i) between men and women, and (ii) amongst women. These relate to work, resources, responsibilities and powers.
2. Assessment of how gender relations have an impact on opportunities, needs, incentives and rewards
3. Assessment of capacity of intervening institutions to promote gender equality goals
4. Estimation of the potential obstacles and resistances to initiatives to promote gender equality and development of strategies to counter these resistances.

WHAT IS THE DIFFERENCE BETWEEN STRATEGIC INTERESTS AND PRACTICAL NEEDS OF WOMEN? DOING A 'GENDERED' NEEDS ASSESSMENT

It is obvious even from the above discussion on strategies that merely fulfilling the practical needs of women does not improve their status in terms of power or equality. Since an articulation of needs is the first step in planning, let us understand this better.

Practical Gender Needs (PGNs) : This is a term used to define women's needs in a way that does not question her subordination or traditional roles. These are often to do with the practical needs of day-to-day living such as housing, water, health care and employment; and obvious and immediate in nature. For example, a woman in dire poverty may receive a piece of land from a benevolent government in response to her practical need.

Strategic Gender Interests (SGIs) : In contrast, these are the needs of women identified on the basis of their subordinate position in society. They may vary from context to context as discussed above and may include issues such as legal rights to freedom from domestic violence, rights to land and property, sexual rights, unequal divisions of labour in the family etc. These are often less obvious and have long term implications. For example, a woman who is not in dire poverty, may still fight with her brothers for equal rights of inheritance to family land. She may not need the land to survive, but it is still in her interests to fight for her rights. The struggle for strategic interests is more difficult and encounters much more resistance than the struggle for practical gender needs. It is the SGIs, therefore, that often get left out of gender planning.

What is the difference between women's condition and position?

The same distinction can be phrased in a different way; improving women's 'condition' relates to provision of basic needs (PGNs) whereas women's position pertains to their economic, social and political standing relative to men.

Practical Needs	Strategic Needs
• Tend to be immediate, short term • Unique to particular women • Relate to daily needs: food, housing, income, health of family etc. • Easily identifiable by women • Can be addressed by provision of specific inputs: handpumps, food, health care services etc.	• Tend to be long term • Common to almost all women • Relate to disadvantaged position, subordination, lack of resources and education, vulnerability to poverty, violence etc. • Not always immediately identifiable by women • Can be addressed by increasing awareness, self confidence, education, strengthening women's organisations and political mobilisation
Addressing Practical Needs • Tends to involve women as beneficiaries and perhaps as participants • Can improve the condition of women's lives • Generally does not alter traditional roles and power relations	**Addressing Strategic Interests** • Involves women as agents or enables women to become agents • Can improve the position of women in society • Can empower women and transform gender relations

It is important to acknowledge that addressing both is critical to the success of planning; addressing Practical Gender Needs alone will not lead to long term improvements for women and may reinforce their subordination. Similarly, addressing Strategic Gender Interests alone may fail as a strategy if practical considerations are not taken into account.

Other steps in gender analysis include collection of gender disaggregated data, and collecting information focusing on gender differences in activities, access to and control over resources and roles and position in decision making processes

Levels of Gender Analysis

Analysis may take place at various levels – individual, household, community, institutional and political. For example, at the institutional level, gender analysis may look at institutional policy and services, organisational structure and staff qualifications and training. At the family level, gender analysis may look at who does what work, how financial resources are controlled and by whom etc.

How to go about gender analysis

Many tools, checklists and questionnaires are available to assist gender analysis in various sectors. However, it is always advisable to use these as a base to create one's own simple tools based on the context and task at hand. As an example, a checklist for indicators associated with health care services with a specific focus on gender is provided in Annexure 2.

EXAMPLE 1: GENDER ANALYSIS OF THE FUNCTIONING OF A PRIMARY HEALTH CENTER

The data was gathered from a focus group discussion of women workers and women patients separately and a meeting of all together as well as interviews with all the staff in the PHC.

Identification of similarities and differences (i) between men and women (ii) amongst women.

- *Work* : Who are the men and who are the women in the workforce and what work are they doing? The ANM and sweeper are women. The doctor, the male worker, the supervisor, the dressor and the peon are all men. All of them come at the same time – but the woman has to balance it with her children's and husband's needs and then come and has to rush home early and drop by for lunch to make sure things at home are fine.

- Who are the patients – about 1 : 1 is the ratio of men to women in the clinic. However both are seen in a common room and queue as there is only one doctor and there is no separate place for examination of the woman – except a bed with a torn mostly gaping screen. Women need more privacy for being examined which is not there. The village had requested for a once a week visit by a woman doctor but a senior doctor at the district office said that women have to be less tradition bound and be willing to be examined by a man. When pointed out what if a man had to show a genital lesion to a woman doctor – he thinks about it and agrees – and says, "what to do, there are no women doctors available". There is a common toilet- but it is dirty and more of a problem for women to access and use. Men use open spaces for toilet purposes which women are unable to do in that locality. Women often come in with children and they have to leave their child with another patient or keep the child on their lap when talking to the doctor and the doctor constantly gets irritated by the child's interruptions.

- Women are unable to come twice or thrice if there is suspected TB for confirmation. Men are more likely to be able to do so- or that is what the register indicates. If we look at the X-rays – many more men then women have had their X-ray taken; about 3:1 ratio. The same is true of laboratory tests register (2: 1) and even of BP measurement where only pregnant women have BP taken. However men and women have equally been exempted from user fees and in X-rays more proportion of women then men have had such exemption.

- When asked the doctor first denies that there is any such discrimination and is genuinely puzzled when shown the register. Then he sort of perks up and states that many women have really no complaints – just vague aches and pains- but they are turning up because they get bored at sitting at home and want a change.Women feel that he does not listen to them and that he is too dismissive of them and their complaints. Men too feel the same but it is less so. It is interesting to note that for the same body ache or other complaint what treatment in fact is given to men and what to women. No patient is advised about malnutrition though indeed most of the woman and many men coming in are malnourished.

- *Responsibilities and powers*: The women are also junior most too. The sweeper is responsible for cleanliness, and the

ANM for a set of 20 tasks - both in the field in the hospital. She also has to be available when the doctor is examini women patients and many aspects of patient examination is left to her. She stays in the place as she has to play t midwife role.Only the sweeper can be asked to do some work by her – all else are senior to her or equal. The men s their role in supporting the doctor and takes turns to do so. No one is helping the ANM though since its her job. And sin the ANM has to be there to see female patients the doctors can be away and know that the ANM would cover the ga

Assessment of how gender relations have an impact on opportunities, needs, incentives and rewards: For many types failures – indeed all except in an outbreak of an epidemic when the male is held responsible - it is the ANM who is considere accountable. Informally since the male worker is not going to the field she is asked why she did not report the epidemic.

- The system has no rewards for either.
- The nurse has no avenues for promotion exceptbeing promoted to LHV and that too after a 6 month training. T male worker does not need training for promotion and because of an active union is likely to get promotion speedi
- Patients are able to access the ambulance for shifting pregnancies to the CHC if there is a need for referral. But everything else they are told to find their own transport – even where the patient is sick.

Assessment of capacity of intervening institutions to promote gender equality goals: Most of the officers at the district office a the state are men.They do not feel that the work allocation and power relationships are gender issues. They are simply j profiles.They tend to sympathise with the doctors' perceptions on gender issues on patient care. The district plan has be made and it has a section on gender – where it says that the health of a woman is the health of the whole family and outlin all that is being done under the expanded reproductive health programme.

Estimation of the potential obstacles and resistances to initiatives to promote gender equality and development of strategies counter these resistances:: The most important , almost universal response when this case study is pointed out is that "so w can be done about it?" or "how can we incorporate it in a district plan?" or at best, "in the training programme we shall raise t issue." Obviously the problem in this area of gender differential is that the system is not sure how to start – or for that matter giv so many priorities and so much being done on expanding the ambit on reproductive health whether it is even practica desirable to start addressing all these gender dimensions now.

EXAMPLE 2: GENDER ANALYSIS OF VECTOR CONTROL PROGRAMME IN HIGH MALARIOUS AREAS: WHAT GENDER MAINSTREAMING AND HOW CAN WE GO ABOUT IT?

Sometimes it is assumed that addressing gender discrimination in health is merely attending better to women's health nee This is an incomplete understanding that almost misses the issue.

Sometimes, it is assumed that gender equality can be arrived at by merely providing opportunities for women to participat a programme in numbers equal to men. However, experience shows that even this is not enough. Though participatio women is an important parameter for a programme to have an impact on gender equality, it is also required to ensure following four principles:

- **Focus on impact rather than activities**: We should look at how our programme will change overall gender relat in favour of women.

- **Focus on equality** as an objective rather than on women as a target group: Thus the target group may be a group of men, institutional practices, legislation etc rather than women.
- **Focus on equitable distribution** of resources, opportunities, and benefits of the mainstream development process. This requires pro-equality interventions to be consciously built into *all* policies, programmes and schemes.
- **Focus on women's participation** at all levels of decision making so that their interests, vision and concerns find expression.

These were defined at the UN Fourth World Conference on Women (1995) at Beijing – which was where the term 'gender mainstreaming' became an internationally accepted concept and goal.

As discussed earlier, all this is entirely conditioned by specific contexts. Thus, it is more a matter of keeping these broad strategic principles in mind than following a fixed format.

As an example, let us see how to use these principles in programming for sexual and reproductive health. It has been discussed in Lesson 1 that reproductive health issues have been understood and treated in a very limited way. The discussion in this Lesson should allow us to understand that reproductive health programmes have generally focused on PGNs rather than SGIs. In fact, they have often gone against SGIs! Therefore, it will be an interesting exercise to turn the gender planning tool on to reproductive health programmes.

GENDER ISSUES IN SEXUAL AND REPRODUCTIVE HEALTH

Orientation: Does the planning of services reflect the broad vision of sexual and reproductive health as defined in the Beijing and Cairo Conferences (see Lesson 1) or does it confine itself to family planning or some other targeted exercise? Does it recognise sexual and reproductive rights and equality of both men and women?

Integration: Can various integrated services (child health, antenatal care, STD management, ante and postnatal care, deliveries and abortions, general health care etc.) be accessed easily and all together in one place?

Clientele: Do the services cater to unmarried women? Do they cater to men?

Staff Training and Support: Are staff 'gender trained'? Are they able to provide privacy, do they have respect for the individual's right to take decisions? Can they respond appropriately to people who have suffered violence?

Targets of Health Promotion: Are adolescent boys and men considered 'targets' for reproductive and sexual health messages?

Content of Health Promotion: Does the content promote gender equality? Do the messages deal with issues like work distribution in the household, the role of men in child care, responsible sexual behaviour and do they counter traditional taboos like not feeding eggs to girls or not allowing them to participate in sports?

It is essential to use the principles of gender mainstreaming at all levels of the programme cycle. These are:

- Situational analysis
- Project formulation
- Project Implementation and Monitoring
- Evaluation

Thus, we may set ourselves the following objectives and questions while programming for health with gender awareness and using the strategy of gender mainstreaming. These points may also be used in evaluating our programme by the yardstick of gender mainstreaming.

1. Initial Analysis: This should take into consideration gender differences in health status, health needs, constraints and priorities. Should take into consideration what community contributions (time, labour, money) are anticipated and who will be making them (men or women or both). It should separately assess the capacity of women and men to respond.

2. Baseline Data: The project should use gender disaggregated data. Has baseline data been collected to assess change in gender equality in any manner also? Is all baseline data that is being freshly collected disaggregated by gender?

3. Consultation and Decision making: Women should participate in the same extent in decision making during programme formulation and implementation as men. It is particularly important to consult women staff members. When seeking community participation, because of the problems of representation and silence, representative organisations of women and women's rights organisations need to be consulted.

4. Objectives and Strategies: The programme should formulate specific goals with respect to women's health and gender equality. (Note: As new gender issues come up during programme implementation, the programme team should be able to recognise them and also modify the programme to deal with them appropriately. Processes for doing this need to be built into the programme specifically.)

5. Service Provision and Programme Design:

- What are the ways we are addressing access to health services? How many women, compared to men, received or used the different types of services? What are the constraints and how can we make access more women friendly?
- We should look at the profile of the service providers in terms of gender. In some programmes the lack of women service providers would seriously cripple programme outcomes. In others, the problem is of stereotyping women for certain roles and decreasing male responsibility. Are all the volunteers and junior workers female and seniors male, or is their a fair mix? While recruiting, can we try to maintain a gender balance? In which programmes is this essential for outcomes?
- Are the services relevant to women's stated needs? Is the package of services provided after

considering women's views as well?

- Is the facility design women-friendly? Examples are toilets, place to change, privacy during examination, residences for women employees, places to avail of, wash or dispose off soiled menstrual pads, places to allow breast-feeding or even older children to be looked after. Facilities for accompanying women to stay with their children who are ill.
- Are specific disease control programmes gender-friendly? Is DOTS programme women-friendly? Are women able to come as often for sputum examination and directly observed drugs? What can be done to improve this? Is leprosy programme women-friendly: when house to house surveys are done for body searching for lesions, are there women on the team? And so on…

6. Health Communication: Men should be addressed as well as women. Messages should be in tune with the requirements of gender equality in the context of the programme. Special care is needed to avoid stereotyping gender roles or emphasising inequitable traditional values and many subliminal forms of gender bias (like training materials having largely pictures of boys and very few girls or communication material emphasising male dominance etc). Most important to note are whether themes of gender inequity impacting on health are addressed adequately in health communication strategies and whether they expose the links between patriarchy and ill health. Issues like early pregnancies or lack of women's ability to negotiate safe sex, "the migrant man returning home" are examples.

7. Training: How many women are to receive training as compared to men? The timing and choice of venue and availability of toilets etc should be done in a gender sensitive manner. The training material should be examined for gender sensitivity. Trainers must keep gender equity issues in mind as well as specifically highlight them during the training. Is there a gender bias in choice of training programmes? Do women receive training on policy and management issues as well as skill training? For example, how many senior nurses have been trained for administrator roles?

8. Gender Analysis Skill Training: Specific training to improve gender sensitivity and gender analysis skills should be incorporated into training programmes and at least some women trained to lead this in each district. This should include skills in gender analysis, data collection and training.

9. Outcome and Impact Indicators: Impact data should be disaggregated by gender. Specific impact indicators should be used to look at changes in gender relations or SGIs through the programme.

10. Workforce Management Issues and Management aspects: Are there promotional avenues for women employees? Is there protection against sexual harassment and assault and a minimum grievance mechanism in place? Are maternity benefits provided adequately? Is there provision for breast-feeding children? Are issues of women's mobility addressed? Are there plans for developing more women laboratory technicians and doctors? Are there plans for teaching more RCH skills including immunisation to men? Why should immunisation, for example, be only a woman's job? Why should not the male MPW share this role especially

where there are geographically dispersed hamlets, making it difficult for the women to cover it alone?

Gender Mainstreaming is really about answering the questions above (which are not exhaustive, only examples) with simple, pragmatic solutions. Solutions that would have been there had there been women engineers in the PWD or more women Chief Medical Officer and Block Medical Officers!! There are now more women at the senior levels – as technical assistants, consultants and administrators – and this has helped. But unfortunately many of them have never worked in the district level and are also working in male dominated environments where many of these problems have been assumed as a given – not open to change. Also most of them would be in the RCH area only – there would for example be almost no women malaria officers or tuberculosis officers even at the national level. It is therefore a challenge of the district health plan to uncover gender inequalities and address them meaningfully.

WHAT IS GENDER BUDGETING AND THE WOMEN'S COMPONENT PLAN?

One definition of gender budgeting reads: "Gender budget initiatives analyse how governments raise and spend public money, with the aim of securing gender equality in decision-making about public resource allocation; and gender equality in the distribution of the impact of government budgets, both in their benefits and in their burdens. The impact of government budgets on the most disadvantaged groups of women is a focus of special attention".

That is, gender budgeting implies the participation of women in decision making about budgetary allocations, as well as allocations for gender equality. It is an exercise to translate stated gender commitments of the Government into budgetary commitments.

It was the Ninth Plan document that first clearly stated the **Women's Component Plan**- 30% of funds were sought to be earmarked for women related sectors. All government departments were also instructed to open Gender Budget Cells in 2005. Central and all State governments were instructed to report the women's component in their budgets and plans and this is done through a process known as **gender audit**.

The Ministry of Women and Child Development is the nodal Ministry in GOI for gender budgeting.[2] As part of this all RCH-II and NRHM project proposals are also required to do a gender budgeting. And if state proposals are aggregate of district plans, districts also need to do a gender budgeting. The use of this tool is in its initial stages and would need to be covered separately.

WHAT DO WE WANT TO ACHIEVE BY GENDER MAINSTREAMING OF HEALTH STRATEGIES AND PROGRAMMES?

Finally, our strategies and programmes should assist in the following ultimate goals:

2. For greater details see Women's Empowerment through Gender Budgeting- A review in the Indian context, Anjali Goyal, Director Finance, Min. of WCD, wcd.nic.in/gbsummary/GBppr_AG.pdf

1. A clear understanding that gender inequality and discrimination are key determinants of ill health in women. Thus a health policy can only be truly effective if it is in tune with and a part of larger strategies for challenging patriarchy of which the key strategy would be the empowerment of women.
2. Better gender disaggregated data and research and programme evaluation that respond to women's needs in particular and provides a better basis for gender sensitive health planning.
3. Design of health care programmes and facilities for health care delivery that respond to gender based differences in health problems and access to health care services, and that consider women's concerns and needs as individuals as well as in relation to children and childbirth.
4. Strategies that address men as well as women for activities relating to child health, fertility and safe sexual practices and that recognise men's responsibilities in these areas.
5. Recognition that women provide most of the paid and unpaid health care on society and pushing for women to have a greater role in policy making at local, state and national level.

MAIN REFERENCES

1. Mainstreaming Gender, Directorate of Public Health and Preventive Medicine, Govt. of Tamil Nadu and DANLEP
2. Handbook for mainstreaming, A gender perspective in the health sector, SIDA
3. Report of State Level Workshop on Gender Training, DANIDA, Tamil Nadu area Health Care Project

I. Review Questions

1. How is the 'empowerment approach' to women in development different from the other approaches?
2. What is the difference between practical gender needs and strategic gender interests? Illustrate with three examples each.
3. What are the basic principles and strategies of gender mainstreaming in health?
4. What are the goals of gender mainstreaming in health?

II. Application questions

1. How gender sensitive are health care programmes that you have been involved with in your opinion? Give reasons for your answer.
2. What are the bottlenecks or resistances to gender mainstreaming as perceived by you? How would you counter these resistances?

III. Project Assignment

Do a gender analysis of any one specific health programme that is running in your district. Make sure your analysis covers all levels of action as well as all steps of programme formulation. Now make recommendations for gender mainstreaming of the same programme.

Lesson THREE

Women's Health Beyond RCH

In this lesson we shall discuss:

- What women's health issues other than related to her reproductive role are
- How to address issues of anemia and malnutrition
- Specific health issues that cause " non specific complaints"
- Possibilities of addressing violence related health issues
- Issues of gender and mental health
- Disease control in gender context
- Issues of exclusion and marginalisation
- Health needs of older women

INTRODUCTION

One of the problems that have been noted over the years as a cause of a poor image for the public health system has been in its inability to address women's health issues holistically. The concern is that though it pays some attention – that too inadequately – to reproductive health, it does not pay any attention to all the rest of women's health issues.

Morbidity Patterns: So what are the illnesses that women get?

One study of women's morbidity showed the following pattern:

1. Reproductive/Gynecological: 19.9%
2. Aches and Pains: 17.9%
3. Fever: 16.9%
4. Respiratory Problems: 12.4%
5. Eye/Ear/Skin: 10.8%.

The above study is from rural Maharashtra.[1] In many other studies, fever (which could be caused by a number of infectious disease) was the commonest problem ranging from a prevalence rate of 18 per 1000 to 31 per 1000 with gynecological illness at 4 to 8 per 1000 as the second most common cause.

Excluding the obvious gynecological morbidity, as far as other reported morbidities go, one national study did not find any gender differentials for an illness except for head, body or back aches which was 120% higher in women in rural areas and 74% higher for women in urban areas.[2]

Morbidity studies are generally difficult and more so with women. Part of the problem is the subjective nature of the study. Many common illnesses like back pain or bodyaches are not even counted as illness by the medical profession. Further, there are common problems like anemia or malnutrition that women would not report at all and may present only as fatigue. Higher socio-economic groups would report an illness when it causes them discomfort or even if their attention is drawn to it, but a wage labourer may report illness only when it prevents them from going to work. One study reports that having women interviewers rather than men itself raises the reporting of illness.

Two illnesses that we need to add on to the list of reported modbidity studies quoted above are mental illness which is estimates at 15% of all women against 11% for all men and anemia and malnutrition which too is higher in women as compared to men.[3]

---

1. Madhiwala, Neha, Sunil Nadraj et al 1998, quoted in Leading Causes of Morbidity and Mortality, National Profile on Women, Health and Development, Editors, Sarala Gopalan, Mira Shiva, a WHO- VHAI publication,2000 pg 165-166- referred to later as the National Profile Study
2. Sundar 1995, quoted in National Profile study
3. Dawar 1996, quoted from National Profile Report

Mortality Patterns:

Women's mortality also remains higher than male mortality in all age groups upto the age of 30. In urban areas the peak differential is at the age of 20 to 25 when the female to male mortality ratio approaches 1.5. In rural areas also the peak is in the same age group with the ratio being 1.42. In childhood the main causes of this are nutritional and common infectious diseases. We studied this along with child health.

In the reproductive age group (15 to 44 years) the top ten causes of mortality in the year 1994 as recorded by the RGI were:

1.	Tuberculosis	(9.2)
2.	Suicide	(6.8)
3.	Heart Attack	(6.2)
4.	Burns	(5.8)
5.	Cancer	(5.7)
6.	Non pregnancy anemia	(4.7)
7.	Respiratory infection/asthma	(3.6)
8.	Acute abdomen	(3.5)
9.	Malaria	(3.5)
10.	Snake bites	(3.4)
	Total	**(52.4)**

Source: National Profile Study

Earlier in the PHRN series we planned for addressing maternal mortalities which also occurs in this age group and which is one of the national priorities. Maternal mortality does not however make it to the top ten list. Yet we all agree that it should remain a priority. The point is that these ten causes – in most of which mortality is preventable, also needs to be planned for. How does the district plan address these issues?

We note that in addition to this we have to factor in the effect of a rapidly declining under-six sex ratio. From 946 in 1951 it has fallen to 927 in 2001.

Summing up we find that non reproductive tract illness accounts for about 60 to 80% of women's illnesses and even higher percentage of deaths. In a number of these illnesses and deaths, there is a gender differential adverse to women. even in those where there is no adverse gender differential in illness prevalence, because of social circumstances the burden on women would be more and their access to care becomes less.

Till the late seventies the emphasis was almost completely on only family planning with much of the assistance in pregnancy and child birth being relegated to dais. In the eighties and early nineties more

emphasis was given to care in pregnancy-antenatal, natal and post natal. It was only in the mid-nineties that the paradigm shifted from safe motherhood to reproductive health care. And it is only with RCH-II, in the middle of the first decade of the 21st century, that there is more emphasis coming on to the entire area of women's health, not only limited to reproductive health issues.

A gender sensitive district health plan would have to go beyond addressing maternal mortality and even beyond reproductive health care issues to including the following health problems amongst its concerns:

a. Anemia in women.
b. Malnutrition in women.
c. Violence related health issues.
d. Some common women's complaints that can get dismissed as non-specific:
  i. Low Back ache.
  ii. Body aches and fatigue.
  iii. Headaches.
e. Mental Health Issues.
f. Major communicable and endemic diseases – and their gender dimension.
g. Health Issues of Socially Excluded & Marginalised Women.

We discuss below how to incorporate these concerns into a district health plan.

ANEMIA AND MALNUTRITION IN WOMEN

Gender Dimension of the problem

The gender differential in malnutrition levels is given below:

Table 3.1. Gender Differentials in Malnutrition (1995-96)

BMI	Status	Males	Females
>18.5	Normal	67.1	59.0
17 to 18.5	1st degree CED (underweight)	16.1	18.2
16 to 17	2nd degree CED (malnourished)	6.5	8.1
<16	3rd degree CED (Severe malnutrition)	6.0	9.9

CED = Chronic Energy Deficiency = Malnutrition.

Source: National Profile Study

Table 3.2 Nutritional status of women, India, 1998-99

Among ever-married women, mean height, percentage with height below 145 cm, mean body mass index (BMI) and percentage with specified levels of BMI by selected background characteristics

Background Characteristic	Height			Weight-for-height[1]				
	Mean height (cm)	Percent-age below 145 cm	No. of women for height	Mean body mass index (BM)	below 18.5 kg/m²	25.0 kg/m² or more	30.0 kg/m² or more	No. of women for BMI
Age								
15-19	150.6	14.7	7,480	19.3	38.8	1.7	0.1	6,707
20-24	151.2	13.0	15,185	19.3	41.8	3.6	0.4	12,928
25-29	151.4	12.4	16,618	19.8	39.1	7.3	1.2	15,030
30-34	151.5	12.3	14,051	20.4	35.0	11.7	2.4	.13,399
35-49	151.2	13.7	29,451	21.1	31.1	16.8	3.9	29,056
Total	**151.2**	**13.2**	**82,785**	**20.3**	**35.8**	**10.6**	**2.2**	**77,119**

In terms of age distribution, malnutrition is highest in the 20 to 24 age group and about 35.8% of women are malnourished.

The NFHS II shows that almost 50% of all women are anemic and 16.7% have moderate to severe anemia.

Table 3.3: Percentage of ever-married women classified as having iron-deficiency anaemia by degree of Anaemia, according to age, India, 1998–99

Age	Percentage of women with any anaemia	Percentage of women with: Mild anaemia	Moderate anaemia	Severe anaemia	Number of women
15–19	56.0	36.2	17.9	1.9	7,117
20–24	53.8	34.8	17.0	2.0	14,560
25–29	51.4	34.8	14.7	1.9	15,965
30–34	50.5	34.8	13.7	1.9	13,595
35–49	50.5	35.1	13.6	1.9	28,426
Total	**51.8**	**35.0**	**14.8**	**1.9**	**79,663**

Source: NFHS 1998-99

Prevention and Cure at the Technical Level

Any case with anemia requires:

1. Iron supplementation to correct the anemia.
2. To find the cause of anemia and correct it.

The main form of iron supplementation is the provision of iron and folic acid tablets. For pregnant women there is a guideline to provide a full course of 100 tablets.

Most women would require more than this for the correction of anemia. Indeed they would require an amount that implies that anemia cannot be fully corrected if detected during pregnancy. Hence the need to identify all those who are adolescent and those who are newly married and ensure that anemia correction begins straight away. The point is that it would be better to treat anemia for its own sake rather than in the anticipation of pregnancy outcomes since it is a cause of such a feeling of fatigue and ill health in women.

In pediatric age groups, the lack of any pediatric formulation in the government supply is a problem. Here again, correction requires administration of a small dose daily over a long time period.

At any rate unless dietary iron improves they would have to be permanently on iron tablets. The importance of dietary measures and their ability to access iron rich foods becomes another major concern. Dietary iron by itself may take too long to correct anemia – indeed it may not be able to correct severe anemia at all. But once anemia is corrected by tablets, prevention of anemia certainly needs to be based on dietary enhancement only. Tablets have little role.

Among causes of anemia the most common correctable cause apart from poor nutrition is hook worm disease and this is so easy to correct (a single tablet of albendazole) that now irrespective of other causes, a correction of this is done anyway.

The other major cause is enhanced blood loss – either form larger menstrual problems or from conditions such as hemorrhoids. Here the importance is on accessing health care facility for this purpose.

For addressing malnutrition- the central issue is access to food and food security. The main causes of adult malnutrition remain hunger and poverty and the loss of livelihoods. This is discussed further in Book 9.

The problem of malnutrition takes on a special urgency and has more specific causes in adolescence and this is discussed along with adolescent health.

Severe malnutrition requires treatment along standard treatment guidelines sometimes in institutional settings. They may present with some inter current illness but the health care provider should be alert to the main cause being malnutrition and be able to initiate institutional care for the same. There is a case for 'treating' malnutrition in adult women aggressively. Such malnutrition occurs most often in women headed households which could form about 10 to 20% of all households. For reasons of desertion or death, there are families that run only on the woman's daily wage income. If the woman is ill, income to the household ceases and in the absence of nutrition her recovery gets prolonged leading to a vicious cycle that rather quickly leads up to severe adult malnutrition. Reversal of this malnutrition could bring back her earning capacity and even a one time effort to do so in an institutional setting gets justified.

Prevention and Management at the Systems Level

For Correction of Anemia:

The central problem of management becomes identification of affected persons and initiating them on treatment. This requires a building up of awareness using both the mass media and interpersonal communication from health workers. It also requires massive screening programmes, especially of adolescents and all those attending the health care facilities. Every Sub-center and PHC is supplied with blood hemoglobin measuring instruments but the laboratory chemical is very difficult to access and in practice the test almost never gets done. Retaining them on treatment is also a problem due to side effects, due to poor quality of pre-treatment counseling and due to difficulties of regular access – all of which can be addressed by the health system.

The second problem is drug supply and logistics. These need to improve as part of the overall improvement of procurement and distribution systems for all drugs and supplies. The system must be responsive to changing patterns of consumption across the various health care providers

Enhancing dietary access to iron rich foods relate to awareness about what are iron rich foods, then in rural habitats enhancing access to such foods by kitchen gardens or from natural resources of the area. However income would be limiting and where this is not easy to overcome, like in urban slums, access to tablets becomes central. However, much can still be achieved in this direction and systems of food security such as the PDS need to respond to the situation of dietary inadequacy of iron by providing iron rich foods.

For detection and appropriate medical inputs where required:

The health care providers need to be sensitised to the medical care issues in patients who present with malnutrition. Sensitisation is required to even detect cases - where the inter-current infection may be

seen but the malnutrition may not be noticed. This is particularly a problem when the infection is tuberculosis or malaria where the management of malnutrition is even more important and where usually the presence of the disease draws attention away from this underlying cause.

Standard treatment protocols also need to include the management of severe malnutrition with or without accompanying illnesses.

VIOLENCE RELATED HEALTH ISSUES

PREVALENCE

Table 3.4 Women's experience with beatings or physical mistreatment, India 1998-99

Percentage of ever-married women who have been beaten or physically mistreated by their husband, in-laws, or other persons since age 15 and percentage beaten or physically mistreated in the past 12 months, according to selected background characteristics.

Background Characteristic	Percentage beaten or physically mistreated since age 15	Percentage beaten or physically mistreated since age 15 by :			Percentage beaten or physically mistreated in the past 12 months	Number of women
		Husband	In-laws	Other person		
Caste/Tribe						
Scheduled caste	27.4	25.2	2.2	3.3	15.4	16,301
Scheduled tribe	23.0	20.8	1.8	3.0	13.0	7,750
Other backward class	23.0	20.7	1.7	3.6	11.7	29,383
Other	15.7	13.6	1.6	2.6	7.8	34,904

Source: NFHS –II, 1998-99

Violence takes many forms. It could be verbal abuse, emotional abuse, physical abuse or sexual abuse. It could be controlling the money, blaming the woman continuously, using her children against her, or isolating her. It could also be making threats of physical violence, or actual physical violence, murder, sexual harassment or rape. Many women are driven to suicide by violence and burnt to death in what are passed off as accidents in the kitchen. Suicide was the second most common cause of death and burns the fourth most common cause in the 15 to 44 age group in the National Profile study.

Violence is most often domestic violence. But there is also violence at the work place, violence during sectarian strife- communal riots, caste based attacks– all of which targets women. Violence by authorities of the state and custodial violence- in prisons, police stations, etc. – is also another significant problem.

Health Dimensions of the problem

Violence leads to a number of "health" problems:

a) Physical Injuries and Severe Pain: assault leading to injuries, fractures, wounds or burns – often life threatening. Note that accidents and burns, many of which have violence related causes, are a major cause of mortality in this age group. In addition pain is the first and most important problem.
b) Sexual Health problems: Abortions may result because of beatings. Unwanted pregnancies and sexually transmitted diseases inflicted by irresponsible sex, often without consent (marital rape) is another common form that violence takes.
c) Mental Health Problems: Depression, anxiety, insomnia (sleeplessness), withdrawal, harmful and reckless behaviour and very often suicide, becomes a major form in which violence affects health. Lack of motivation and sense of low self esteem is commonplace.
d) Behavioural Problems in children: Boys learn to be aggressive and copy the father's behaviour patterns. Girls learn to be meek and submissive, sometimes quiet and withdrawn. Children also develop nightmares and other fears. Growth retardation, and frequent illnesses like stomach aches, headaches and asthma are also well known. Violence directly on children to make the woman feel helpless is also a form of violence against women.
e) In the community, violence and aggressive behaviour and domination, becomes more acceptable and prevalent, women's participation becomes less and this harms everyone's quality of life. High relationship to alcoholism and substance abuse as a cause, and sometimes as a result.

There are also various forms of mortality associated with such violence:

a) Sex selective abortion
b) Female infanticide
c) Murders by burns, poisons or other direct forms of violence
d) Suicide due to depression or due to harassment
e) By starvation and neglect – especially in old age and in the first year of life

Prevention and Management at the Systems Level

There are two ways of analysing this question:

a). Why are women subject to such violence?

1. Because she is seen as a man's property under his ownership, to do with as he pleases. In sectarian violence women are also attacked for it is seen as an attack on the assets of the whole community and family and their helplessness if they cannot "protect their women".

2. Because violence works: He can win the argument and get his way. He may get a sense of power and control which is in contrast to his frustrations and failures and oppression in society.
3. Because there is a false idea prevalent in society of what it means "to be a man". To exercise male power and domination over her is considered legitimate and "natural." In a society where many persons do such violence and get away with it, this becomes the social norm,
4. Because he feels safe and can get away with it because of attitudes like "it is their domestic affair – we should not intervene in it". No one questions it.

b). Why do women suffer such violence, often in silence?

1. Because of fear – because of threats to her life and her children. She may feel that she has to stay to protect them or other loved ones or herself.
2. Because she has no money and place to go: Women seldom own assets. The parental home is often closed to her, in the belief that only then will she learn to adjust – which means – learn to suffer in silence, for it is her lot as a woman.
3. Because she has no education and skills to support herself.
4. Because she has no protection. He will always be able to come after her and do her violence.
5. Because of shame and little self worth. Somehow the violence becomes her fault.
6. Because of cultural and religious beliefs. She is expected as a good women to suffer and keep the marriage bond sacred – no matter what he does.
7. Because she still loves him – and hopes that he would change.
8. Because there is guilt about breaking the family and leaving the children fatherless – or motherless.

From the above analysis one can work out what it means to address this issue. All of it need not be done by the Health Department.

At the "individual level" there are five ways to help, all of which have systemic/district equivalents; there is also another way that acts only at the social level.

At the Individual Level	At the District (systemic) Level
Medical Help: Provide prompt and sympathetic medical treatment when required. This includes mental health services.	Sensitise health care providers on being able to identify and treat victims of violence with sympathy and concern. Train on some aspects – like the management of a case of rape or sexual assault, or post traumatic stress syndrome, depression etc. Arrange/refer the patient to those trained for the four other dimensions of care
Counseling and Support: Talking to the woman and explaining that it is neither an individual problem or a family issue – and helping her plan to put an end to this. It may be to convince the husband, or stand upto him or to leave him. But even where she cannot make the choice- someone to talk to and share her suffering with is essential.	Arrange for counseling and support systems in the community through the community health worker and at each facility. Ideally the community health worker or a nurse in the facility should be trained on providing counseling. Can be packaged along with other counseling training and delivery.
Refer her/escort her to a place of security from which she can rebuild her life- if she wants to or has to leave	Set up services to help women who leave. Working women's hostels, half way homes need to be available in each district.
Social Pressure: Some members of the community meet the family as a group and make the situation of violence unacceptable. The community should make the domestic issue – or any other form of violence into a community issue – and show that it is not acceptable.	Train self help groups and women's health committees to see that a group visit is made to houses where incidence of violence is reported. Should actively intervene if they hear it is ongoing.
Use legal pressure- threaten to go to the police or the legal aid clinic. There are now effective laws available against domestic violence, against sexual assault or harassment etc.	Arrange for well publicised legal aid clinics, special women's police stations, family courts etc to allow for legal pressure.
	Challenge existing norms through role plays, street theatre and appropriate culture based media and mass media.

(The above discussion is sourced and adapted from 'Where Women Have no Doctor', a resource guide for women's health, published VHAI, sponsored by Hesperian Foundation and UNFPA.)

COMMON "WOMEN'S" ILLNESSES

Prevalence

We noted earlier that a considerable part of women's illness could be dismissed as trivial or irrelevant by the health care providers, though in fact women are quite distressed and incapacitated by this. We also noted that though there is no gender predominance in the female sex for many of these, three of them – headache, back aches and body aches do have a higher prevalence in women.

To this we also need to add abdominal pains, problems of the urinary tract, and occupation related diseases.

Headaches:

Both due to mental stress and due to hormonal problems. Sometimes headache can be severe and incapacitating, along with inability to withstand bright lights, and then vomiting. These headaches are called migraine and occur more frequently in women. Most often the headache is due to stress and this is called tension headache. Sometimes headaches are indicative or more serious progressive diseases like hypertension or even brain tumors.

Backaches:

Low back ache is the main symptom of pelvic inflammatory disease that has a high prevalence and is often missed. This is discussed in the next Lesson. Low back aches are also a feature of a number of occupations – from working in agricultural operations in the fields, to carrying water or other heavy loads, to prolonged sitting in one position in many jobs like beedi rolling or weaving – especially in the unorganised manufacturing sectors. Even much of household work – sweeping, wiping the floor, washing clothes, cooking on the floor etc. – impacts the low back. These require postural awareness and training, exercises and, at times, pain relief also. Most important is to have adequate rest and to redesign the work place for prevention. A health care provider should find the cause and counsel the patient and show her the exercises to do etc. In most crowded outpatient situations it becomes easier to merely prescribe a pain killer- and since this is what the patient expects, it is a quick solution. Pain killers as a rule need to be avoided because in such a situation pain is a defensive mechanism limiting oneself from injuring the body further. Chronic overuse of pain killers has its own side effects.

Body aches:

This could be related to wide variety of causes. Lack of sleep is a common cause. Anemia, fatigue and malnutrition are also common causes. Beatings – which they may refuse to volunteer information about – has to be specifically asked about. Also any other illness and fevers come along with body ache. Body ache certainly denote illness – and one has to take it seriously. It could be caused by mental stress also, but before concluding at a mental cause, one needs to carefully rule out physical illnesses. Often the woman is just opening up to the issue of health and if specific questions are asked about gynecological complaints, or other symptoms she may come out with them.

In the district plan

The only concern is to see that such patients are understood and appropriate protocols followed by health care providers at that level. It is a question of credibility for the system. The bulk of the outpatient attendance may be for these complaints. But if the women go away after facing rude behaviour or their complaints were treated dismissively they would lose confidence to come back to this facility when they have a more serious complaint.

MENTAL ILLNESS

Prevalence

The reported prevalence of mental illness varies. Some studies quote it at 24 per 1000 and others would go upto 129 per 1000. All the problems we listed earlier for studying morbidities applies even more so to the study of mental health. The reporting is more subjective and it is even more sensitive to interviewer bias.

> *Social stigma carries a greater personal and social cost for women than for men. Whereas most women would consider it their duty to take care of a mentally ill husband, the mentally ill wife would have often to fall back to her natal home for support.*

The studies also show that whereas the common mental illnesses like neuroses, hysteria, depression affect women more, the more serious illnesses like schizophrenia show no gender differential. Also we note that about 50% of mental illness affect women during their reproductive age period.

As with all illness, fewer women suffering from mental illnesses seek help and use mental health facilites and facilities also have less provision for women. Gender sensitivity and culture sensitivity in mental health care providers and in all health care providers for mental illness is also more of a problem.

Social stigma also carries a greater personal and social cost for women than for men. Whereas most women would consider it their duty to take care of a mentally ill husband, the mentally ill wife would have often to fall back to her natal home for support. Desertion by the husband is common place. To worsen it all, the Mental health Act is all too often used to get rid of the unwanted spouse and there are enough shameful cases of mental health care providers being complicit in this. It is not surprising therefore that suicide ranks as the second most common cause of deaths amongst women in the reproductive age group 1995-96, RGI as quoted in the National Profile Study. Gender based victimisation accounts for almost one in every five healthy years of life lost to women between ages 15 to 44.[1]

Management of Mental Health Issues

There are actions that are possible and required – preventive, promotive and assistance in the curative process that can be rendered at the level of the community.

1. World Bank study, quoted by Davar ,1999 from National Profile Study.

There are also actions largely in continuing treatment, and secondary prevention that are possible at the level of the primary health center and the peripheral health facilities if health care providers at these levels are sensitised and trained on this. Appropriate standard treatment protocols that such health care providers can use are now available.

The focus should also be on building a good mental health referral center at the level of each district hospital – if needed by linking up with a private sector psychiatrist, if there is none available in the public sector.

These issues of mental health are handled with some detail in the separate section on mental health in one of the optional modules of this course.

DISEASE CONTROL IN THE CONTEXT OF GENDER

There are a small number of diseases that cause a major part of the morbidity in both men and women. This list of communicable diseases includes first and foremost tuberculosis, then the vector borne diseases of malaria, kala-azar, filaria, then HIV/AIDs and then leprosy. Of the non communicable diseases, blindness, iodine deficiency, sickle cell disease, and fluorine deficiency are noteworthy. These diseases, most of which are chronic, are largely male predominant diseases - but they constitute the common causes of women's ill health also. For example, tuberculosis is the major killer amongst women.

Each of these diseases has a gender dimension with implications for the suffering that women face. Common to all is that women:

- access care later and less often and less completely – thus having more adverse outcomes
- face a heavier burden of stigmatisation and social exclusion and isolation because of disease
- get less support during their illness and face a greater nutritional crisis.

In addition each of them may have more specific gender dimensions, or one of the three above dimensions may impact in a specific way.

Tuberculosis for example is the most common cause of death in adult women. But in addition genitor-urinary tuberculosis can cause infertility which is usually difficult to diagnose and treat and can cause chronic debilitating illness. Filarial chronic leg edema can damage the chances of marriage for any woman and even after marriage can cause her social exclusion. Iodine deficiency of the mother can lead to her children being born with severe mental retardation. Malaria is the ninth most common cause of mortality.

In adolescents the age distribution of HIV is almost equal but with increasing age the disease becomes predominantly male. However the efficiency of man-to-women transmission is much higher than woman-to-man transmission, and therefore women could face a much higher risk of disease for the same degree of exposure.

Stigmatisation occurs in both genders but its consequences in leprosy for the women was much worse for till recently it was acceptable as a grounds for divorce. Searching for leprosy in house to house searches was less efficient in detecting cases in women, for all employees of the leprosy control units were men.

> *Most health problems have no gender differential in prevalence, but certainly have a gender dimension in their effect on individuals and communities... The district health management therefore needs to be sensitive to these gender components.*

This goes back to the issue of gender mainstreaming. There are many health problems that occur exclusively in women, or predominantly in women. Though most of the problems have no gender differential in prevalence, they do have a gender dimension in their effect on individuals and communities.

The district health management therefore needs to be sensitive to these gender components and ensure that in each of these disease control programmes and in the way in which facilities are managed these gender components are attended to.

ISSUES OF EXCLUSION AND MARGINALISATION

There are a number of women who suffer doubly because they are women and because they have in some way or other been additionally marginalised or excluded from society.

These include the following categories:

a. **Widows**: These women suffer indignities in Indian societies. Often they are pushed out of homes or destitutes. The situation could be worst for young widows who are illiterate. The estimated number of widows in 1992 was 8.1% of the total population – a staggering amount. Though a well recognised problem with widow marriage being one of the most important social reform movements in the pre-independence era – the situation for most young widows is still desperate.
b. **Single Women**: They may be widows or they may be divorcees. Or they may be unmarried. Quite commonly they are deserted women or where due to alcoholism or other causes there is in effect no male 'protection'. The census data gives an estimate of around 24 million single women households. Where these households are composed of daily wage earners – they are particularly vulnerable to the social consequences of disease and a magnified effect of their social circumstances on the nature of sickness they face.

c. **Women in Special Circumstances**: In police custody, in mental hospitals, in orphanages, in destitute homes, and even in some ashrams are especially vulnerable to disease and violence of various forms.
d. **Commercial Sex Workers:** Commercial sex workers are not counted as families – though they may be having children. No services reach them and yet they are the most vulnerable to disease. Violence is a daily occurrence of life and has usually taken its most maleavoent forms.
e. **Physically Challenged Women**: They are particularly vulnerable to disease and violence both within the marital home and outside marriage. Due to poor living and working conditions and access to care the population of the blind and the physically challenged in India is one of the largest in the world and there is much work to be done in prevention as well as in management.
f. **Elderly Women**: Both men and women suffer as victims of old age, but women suffer a double disadvantage making them more frequently vulnerable and more vulnerable. The loss of status and influence, the lack of property or security contributes to her victimisation if there is a break up of the family or dispute within it. The health system also remains poorly sensitised to the health needs of old people, especially old women.
g. **Migrants, Refugees and Displaced Women**: The central problem is the stress or break up of the family, the loss of traditional support systems, the abysmal working and living conditions, often the lack of employment and security, and a near complete absence of access to even the most basic of civic services. Very often they do not even figure in any collection of data.

Why is it important to consider such categories of women? Does it not draw away our attention from reaching out to all the poor because effectively reaching out to these sections would take a disproportionate part of the health resources available?

This is a common perception within the health system and often even in civil society. So let us articulate why one needs to attend to their needs.

a. Because they are human and have human rights.
b. Because in absolute numbers when all such groups are added up they are a huge number. (In classical terms that would significantly reduce productivity and 'spoil' our health statistics).
c. Because it is the mark of a civilised society to do so, and even sections representing the poor need to learn to look to the needs of all soceity – going beyond their own sectional interests.
d. Because the values of compassion and caring are central to human society and bringing these sections onto the radar helps enrich all our lives.
e. Because it is so eminently do-able. Very often it is not the cost but the sensitivity that is missing. The compassion that got replaced by statistics and targets. Yet the challenge of planning is to make it inclusive and bring such sections into the planners' sight.

How exactly one could do so is addressed in a later module.

HEALTH NEEDS OF OLDER WOMEN

RCH II, which is the key component of the NRH that addresses women's health needs, focuses primarily on safe motherhood, family planning, and on infections of the reproductive tract among women 15-45 years of age. Indeed it is often the case that after a woman has undergone a sterilisation operation she ceases to exist for the system, which is oriented towards these services.

Women experience a range of gynaecological health problems during and beyond their reproductive lives, in part due to the lack of care during pregnancy and delivery and high parity. Women continue to face a gamut of reproductive health problems, such as infections of the reproductive and urinary tract, incontinence, uterine prolapse, and cervical cancers. Hormonal changes contribute to increasing risk of cardiovascular disease and osteoporosis, in turn leading to fractures. Older women also face the lifelong effects of gender bias and low social status. Years of poor nutrition, hard physical labour, multiple pregnancies, and limited access to health care, mean that women enter old age in a state of chronic ill health.

Access barriers are as important for older women as younger women, and perhaps more so. Care seeking for such conditions is beset by the issue of silent suffering as most women in older age cohorts believe that such issues are part of growing old. Physical and financial limitations may further minimise access to care.

Apart from cancer registry data collected by large tertiary hospitals, there is little available information on the mortality and morbidity among older women. Planning for health needs of older women requires data on major causes of morbidity, disaggreagation by rural/urban residence, and age. District planning should factor collection of such data as a first step.

Currently health programmes are not oriented to providing services for older women beyond the reproductive age cohort. Provider understanding of the physical, much less psychological and social problems of aging women is limited. Health care providers at the district level should be sensitised to the need to screen older women for reproductive and other health problems. Awareness campaigns and sensitisation of grass roots workers are an important first step in raising community awareness on the needs of older women. Screening programmes for cancers of the reproductive tract and breast, and other gynaecological morbidities are perhaps easier to integrate into current provider training.

Since these interventions are not part of current programming, new demands will be placed on the health care system and on providers. Thus the focus at the district level should be on data gathering to inform policy and programmes.

I. Review Questions

1. What are the disease categories that are more prevalent in women?
2. What are the technical interventions needed for prevention and correction of iron deficiency anemia? What are the district level planning and managerial implications of these technical interventions?
3. What are the different interventions that would assist a woman facing violence? How does this translate into activities of a district level plan?
4. Why are suicides and burns so high up in the list of causes of women's mortality? What are the planning implications of this for the health sector?
5. All disease have a gender dimension? What do we mean by this with reference to women's health?

II. Application Questions

1. Is it a viable idea to screen all women for iron deficiency anemia – once a year. What would be the cost implications? If it is not what is the next best option to make each woman aware of the degree of anemia she has?
2. What are the most common women's health problems in your area?

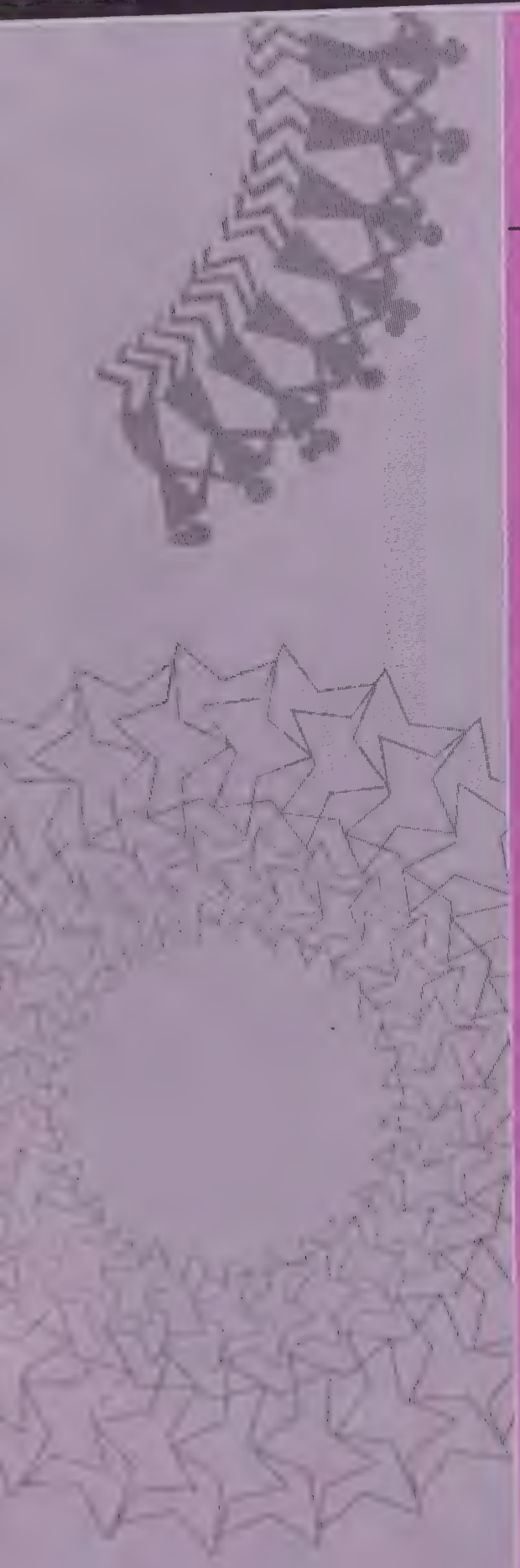
III. Project Work

1. Can you find out the recorded incidence of suicide in your district? What would be sources for such information? How can you make a general estimate from the sample or data source you get? Can the same approach be taken to find the incidence of snake bites? What are the gender dimensions of these two problems in your area?

2. Draw up a district plan that addresses one of the women's health issues – beyond RCH at the level that it is possible to do so now. Note – that such a plan need not be run by the Health Department – it could be by the Women and Child Department or some other department. It could also be by the Health Department.

Lesson FOUR

Reproductive Health beyond Safe Motherhood



In this lesson we shall discuss:

- Elements of reproductive health other than care in pregnancy
- RTIs and STDs and how do they relate to each other
- Strategies for the management of RTIs and STDs
- Systems for management of infertility
- Issues regarding safe abortion services
- Issues as regards malignancies (cancers)

INTRODUCTION

The Programme of Action of the International Conference on Population and Development (ICPD) at Cairo in 1994, defines Reproductive Health as physical, mental and social well being, and not the mere absence of disease, and the ability to exercise one's human sexuality without health risks.

Reproductive rights therefore imply the rights of women to:

- Regulate their own fertility safely and effectively, by conceiving when desired, terminating unwanted pregnancies and carrying wanted pregnancies to term
- To bear and raise healthy children
- To remain free of disease, disability, fear, pain or death associated with reproduction (and the reproductive system) and sexuality

So what should be the components of reproductive health care services?

1. Care in pregnancy and child birth.
2. Services for child survival.
3. Prevention of unwanted pregnancies: Contraception.
4. Management of unwanted pregnancies: Safe abortion services.
5. Infertility services.
6. Nutritional services to support vulnerable groups.
7. Prevention and treatment of reproductive tract infections and sexually transmitted infections.
8. Prevention and treatment of gynecological problems including cervical cancer.
9. Screening and treatment of breast cancer.
10. Reproductive health services for adolescents.
11. Health, sexuality and gender information, education and counseling.

Nos. 1 and 2 have already been extensively covered in the earlier books. No. 3 is covered in the next two lessons. Nos. 10 and 11 occur in the seventh lesson of this book. Nos. 4 to 9 listed above are discussed in this lesson.

ADDRESSING REPRODUCTIVE TRACT INFECTIONS

Reproductive Tract Infections are a major problem in most Indian contexts. This has been documented by many studies. The exact frequency of such illness and their nature varies between different studies. The better the rapport between the interviewers and interviewees, the higher the morbidity (illness) reported. Even on clinical examination and testing, the studies vary widely in the nature of estimates of morbidity and their pattern and even on their relationship to the self reported incidence of such morbidity. In the table below

we find that in two studies the prevalence of gynecological morbidity went up on examination by 37 and 31% respectively. On the other hand clinical studies had a lower estimate in four studies – by 22% in rural West Bengal, by 39% in Baroda , 41% in rural Gujarat and 23% in rural Rajasthan – while in only one study was the prevalence the same between self reporting and medical examination.

Table 6.1 Gynecological Morbidity

Area of Study	Authors	Percent of women self reporting Gynecological Morbidity	Per cent of women with morbidity by clinical examination & lab tests	Average(mean) number of morbidities byclinical examination
Rural Maharashtra	SEARCH, Ghadchiroli (Bang 1989)	55	92	3.60
Rural West Bengal	CINI(1994)	65	43	1.22
Bombay	Streehitakarani(1994)	74	74	1.79
Baroda	Baroda Citizens Council(1994)	65	26	1.99
Rural Karnataka	Bhatia JC et al.;IIM;(1995)	39	70	—
Rural Gujarat	Sewa-Rural(1994)	84	43	1.17
Rural Rajashthan	Koenig et al (1996)	100	77	—

Source: Reproductive Health; National Profile on Women, Health and Development. Ed Sarala Gopalan, Mira Shiva, VHAI & WHO publication, New Delhi, April 2000, pg. 197.

This variance obviously indicates a fair complexity in criteria of reporting and diagnosis. However despite the wide difference it is clear that there is enough data to show that the prevalence of gynecological morbidity is high across the country. Even the lowest estimate of the disease by clinical examination would make it one of the most prevalent morbidities in society.

We also note that many situations exist where:

a) Women report high morbidity – and the examined morbidity is lower. This may be attributed to the fact that many complaints may not relate to a visible lesion on examination. Menstrual disorder being a typical example.
b) Women report high morbidity – and the examined morbidity is much higher. This may be attributed to the fact that many women fail to report morbidity, because of the culture of silence.
c) Women report high morbidity – and the exact morbidity is high – but does not co-relate with the symptoms they reported. This may be attributed to women indicating they have problem in a

general way and leading the health care provider to a more serious underlying problem or at least a problem that they are unwilling to talk about openly. For example, practicing clinicians recognise how often a woman who indicates a trivial problem turns out on examination to have a major prolapse!!

Such are the complexities in the area of self reporting that it becomes difficult to generalise and conclude on a general pattern.

Corelating Gynecological Morbidity with Reproductive Tract Infections and Sexually Transmitted Diseases

Not all gynecological morbidities are Reproductive Tract Infections, though the studies indicate that if we exclude menstrual disorders this is the most common cause accounting for upto 70% of the morbidities. Simultaneously, many of the Reproductive Tract Infections are not Sexually Transmitted Diseases and many Sexually Transmitted Diseases (STDs) do not present as Reproductive Tract Infections (RTIs). Thus Hepatitis B and HIV the two most feared of the STDs do not present any gynecological problem. Syphilis too in women is seldom accompanied by any RTI. Thus addressing RTIs alone does not address all of STDs and vice versa.

The popular myths and misconceptions regarding these plus the culture of silence – the unacceptability and embarrassment that people face when talking of these – are often caused by a confusion of these categories.

In terms of frequency in order of priority of the self reported complaints were as follows.

1. Menstrual disorders
2. Excessive discharge
3. Low Back ache
4. Lower abdominal Pain
5. Dysperunia (pain or discomfort during sexual intercourse)
6. Infertility (3-5%)

Many of those with complaints had more than one complaint and the order might differ in different studies but not significantly. Menstural disorders was the most common complaint in all but two studies. In these two studies excessive discharge (what is often referred to as white discharge) was the most common complaint.

On examination the frequency table showed the following:

1. Cervicitis
2. Pelvic Inflammatory disease
3. Vaginitis
4. Cervical Erosion
5. Prolapse
6. Infertility

Again the order of priority was slightly different in different studies but not signifcantly so.

Amongst laboratory tests for infection one study – the Karnataka study- showed 18% for baterial vaginosis, 8% for trichmonal diseasess – which is sexually transmitted, 5% for candida which is usually not sexually transmitted. 37% had mucopurulent cervicitis and 7% had urinary tract infection and less than 1% had Chlamydia or gonorrhoea. The study concluded that 70% of the all women had reproductive tract infection. As if this was not enough confusion we have to contend with another factor- many infections, even serious sexually transmitted infections like syphilis can be asymptomatic. Thus there is no need to seek health care at all!!!

Management of RTIs

The issue of managing RTIs tests the whole of the public health system. For here is a condition that

- has a high prevalence, and
- is a prime challenge to the claim of a gender sensitive health system.

Yet its management

- does not contribute to the major goals – of reducing MMR, IMR,
- cannot be addressed by a single vaccine or any mass drug administration or other "magic bullet"; and
- requires a competent multi-tiered facility pyramid functioning with quality and using standard treatment protocols at all levels to manage.

Little surprise therefore that till the mid-1990s RTIs were hardly there on the agenda. Even after that, though it has been there on paper, it could not be pursued within the logic of the system as a whole and hence has seldom been realised on the ground. It has been found that a very small proportion (only 5-10%) of people suffering from the disease attend public STD health care facilities.

This recognition of the importance of management of RTIs and STDs changed with the arrival of HIV as a major public health problem. Because of the association of STDs with HIV, and because of the inseparability of STDs from other RTIs the entire areas has gained a greater centrality in programme visibility and funds than was available before. By 1996 based on the ICPD recommendations, the safe motherhood programme became re-designed as the Reproductive and Child Health (RCH) Programme.

RTIs, STDs: The Gender Perspective

Most women have very limited understanding and awareness about reproductive health symptoms related to RTIs. They either frequently ignore them or do not associate them with RTI/STDs.

The taboos surrounding sexuality and STDs lead to a situation where people, particularly women, seeking health care for STDs are stigmatised. This is especially the case where STD care is provided through easily identifiable specialist STD Clinics.

Women feel uncomfortable being examined by male doctors, but very few female doctors are available in STD Clinics. Thus even if women attend STD Clinics, they are usually not examined properly and the necessary treatment may not be given. Health care providers may not know how to politely probe these issues and may ask questions that are offensive and rude.

In clinics where women are examined there is not enough privacy. There are other patients, often acquaintances, crowding around them. There may be no private space even for vaginal examination.

It s obvious that the issue of STDs and RTIs received a new found importance as a result of its links wth HIV in the 1990s. Let us understand this further:

STD Control Programme in India

Even before the country achieved independence, a National STD Control programme was started in 1946. This programme continued to operate till 1991. With the spread of HIV infection in the country and because of the strong relation of HIV with STD, the programme was brought under the purview of National Aids Control Organisation (NACO) in 1992. The importance of treatment and control of STD in relation to HIV infection was recognised by NACO. After taking over the STD control programme, NACO made it an integral component of AIDS control policy.

The link between STDs and HIV

The need to plan for both of these conditions together arises from the following five considerations.[1]

- Increasing evidence suggest that STD significantly enhance the acquisition and transmission of HIV.
- The predominant mode of transmission of both HIV infection and STD is through sexual route, other routes of transmission are both blood and blood products, donated organs and tissues, and infected women to their new-born.
- Many of the measures for preventing the sexual transmission of HIV are the same as for prevention of STD.
- STD clinical services are important access point for persons at high risk for both HIV and STD, not only for diagnosis and treatment, but also for health education counseling and prevention.
- Trends in STD incidence and prevalence sexual behaviour and are easier to monitor than trends in HIV sero-prevalence and thus valuable for determining the impact of HIV/AIDS control programme.

As a result of this understanding, the following objectives were envisaged for the STD control component of the National AIDS Control Programme:

1. Reference: Website of the National AIDS Control Organisation.

- Reduce STD cases and thereby control HIV transmission by minimising the risk factor.
- Prevent the short term as well as long term morbidity and mortality due to STD.

In order to accomplish these objectives, the following strategies have been incorporated in the strategic plan for the prevention and control of AIDS in India.

Strategies for Addressing RTIs/STDs

The broad strategies for controlling STD, as outlined in the strategic plan for the prevention and control of AIDS in India is given in the quote below. This could be fully integrated with the plan to manage RTIs as shown by the additions to the quotation in italics below:

a) Adequate and Effective Programme Management.
b) Prevention of the transmission of STD/HIV infection through IEC and promotion of safer sexual behaviour by the use of condoms.
c) Adequate and comprehensive case management including diagnosis, treatment, individual counseling *for STDs and for RTIs* with partner notification and screening for STDs.
d) Increasing access to health care for STD *and RTIs* by strengthening existing facilities and structures and creating new facilities wherever necessary.
e) Early diagnosis and treatment of mostly asymptomatic sexually transmitted infections through case finding and screening.
f) Special emphasis on early detection and prompt treatment of STDs and other *RTIs* among high risk groups through targeted intervention projects.

Strategy 1: Develop adequate and effective programme management

- At each district we could suggest a nodal officer who would attend to ensuring that every facility is equipped with standard treatment protocols and is providing services in their respective facility in accordance with it. He/she would also initiate, help plan and supervise ensure that the IEC and community participation activities are carried out. The nodal officer would also receive the monitoring reports.
- At the district level there would a referral center – the STD /RTI clinic. This needs to be equipped with the drugs, consumables and laboratory support for diagnosis and treatment. Often an STD clinic becomes part of the dermatology (skin) department or the dermatologist's work. In places with adequate referrals there may be a clinic held everyday with a medical officer and nurse posted there. This would be ideal. If there is not enough case load then the STD clinic operates only once a week. This clinic acts as the apex of the STD/RTI programme at the district level and in turn they would have a referral arrangement to the medical college hospital. There are conditions like genital prolapse and stress incontinence that are major obstetric morbidities and need priority treatment which only the medical college or a gynecologist in a district hospital could provide.
- There are problems with the STD clinic and its integration with RTIs. RTI is managed by the

gynecologist- though the gynecologist may prefer to refer the STD cases to the STD clinic. Thus the gynecologist usually does not attend the STD clinic and women face considerable embarrassment to go to such a clinic. The male with STD problems may present to department of medicine and surgery and then be referred to the STD clinic. Since it is difficult to popularise this clinic, and doing so may also further inhibit health seeking due to stigmatisation, the STD clinic may in fact have poor attendance. In which case it may be better to manage the situation as suggested for CHCs below. We note that today only 8 to 10% of persons with such illness come to the public sector and part of the reason is that access through the private sector is much more discrete.

Strategy 2: Promote IEC activities for the prevention and transmission of STD and HIV infection.

Within the parameters of National AIDS Control Programme, IEC activities have been designed for the prevention of STD and HIV infection. These include raising of awareness and promotion of appropriate health care seeking behaviour of the people.

Awareness generation activities are being implemented to educate the people for:

- responsible sexual behaviour and safe sex
- advantages of condom use.

STDs/RTIs through Behaviour Change Communication

a) One need not suffer in silence, most such diseases can be cured.
b) There is no need for embarrassment- lot of others are taking treatment for the same. And not all gynecological illnesses are RTIs.
c) Usually for STDs – both partners need treatment.
d) Simple rules of genital hygiene need to be known.
e) Sexuality is natural and beautiful. Counseling sessions should be available and attended to know about how to keep it healthy and safe.
f) The exact venue and time of STD clinics and place where treatment is available needs to be publicised.

Like in all BCC work audience segmentation and the combination of media, message and communicator is critical to outcomes.

Thus one audience segment would be unmarried young men and women who are out of their teens and in various small jobs. Another audience segment may be adolescents in school. A third may be newly married couples. The fourth may be middle aged couples. A fifth may be migrant labor and so on. For each of these groups the message gets modified and the way of reaching it to them changes.

One specific BCC strategy being followed under the AIDS control programmes is the Family Health awareness campaign – a series of Health Camps conducted in the village cluster /sub-center level with good publicity. These camps were used for education, for counseling individual couples and for offering

check up and treatment for those with reproductive tract related problems.

Strategy 3: Make adequate arrangement for comprehensive case management including diagnosis, treatment, individual counseling, partner notification, and screening of other diseases.

Creating Guidelines: It is important to construct guidelines for the following categories:

The Village level community health worker:

This would be use a syndromic approach[2]

- The male and female multi-purpose worker and the nurses in the sub-center and primary health centers. This too would use a syndromic approach.
- The medical officer in the peripheral health facility. Due to lack of laboratory facilities this would also have a large syndromic component mixed with the usual guidelines.
- The STD specialist and for the gynecologist. This would be disease based approach. Two sets of guidelines have been published and distributed for use in all first level Health care facilities and for reference for STD specialists from the national center.

The Syndromic Approach To STDS / RTIS

The syndromic approach is a method by which a group of signs and symptoms is treated by a set of medicines that cover all the causes for those signs and symptoms, as against making a specific diagnosis. This has many advantages where STDs and RTIs are concerned:

1. People with STDs are examined and treated at the time of their first visit to a health care facility.
2. Even if drugs cost more, treating in this way is less expensive in the long run because more people are cured the first time they come for care.
3. Approximately 6 out of every 10 STD patients have two or more different infections at the same time. With the Syndromic Approach, multiple infections are considered
4. from the beginning and patients are given effective drugs.
5. Syndromic Approach is well-suited for primary health care services and even for rural health posts because it does not require a laboratory to be available.
6. It is easy for non-specialised health care workers to use flow charts to make a diagnosis and treat patients.

Adapted from 'Syndromic Case Management of Sexually Transmitted Diseases; A Guide for Decision-makers, Health Care Workers and Communicators'; Developed by STD & AIDS Programme, World Health Organisation.

Training on Guidelines: Once guidelines are created, there needs to be systematic training on this. This could be done by integrating two to three sessions on this topic in an integrated training programme for each cadre of staff. Or it may be a short session of two days just to distribute and explain the guidelines.

Counseling: Another major concern is the provision of counseling. This requires some training and some interest in doing so. Not every doctor would have the interest or skills to provide counseling even

2. Note that IMNCI also uses the syndromic approach. Refer lesson 5 Book 3

if he were to have the time. Most programmes either employ a social worker or a nurse to do this. In Tamilnadu and in some other states one suggestion has been to consider attaching an NGO to each facility. The NGO identifies two or three persons who are trained as counselors and who attend the STD clinic, or its equivalent, daily and provide counseling. They would do it with more interest and patience and get a better result. This could be linked to counseling in the adolescent clinic and in the contraception and birth control clinic too.

Contact tracing almost never occurs in our settings though it is routine in many developed countries. The idea is that if we contact the sexual partner from whom the infection was contracted one can offer a cure to him or her and prevent it from spreading further. Again this is an action that needs to be piloted and one would then require some social workers dedicated to this work. Partner notification – information to the spouse of the person also needs to be undertaken by the counseling services. Again it is advantageous to have an NGO undertake this.

Strategy 4: Increasing access to health care for STD/ *RTIs* by strengthening existing facilities and structures and creating new facilities wherever necessary.

- One approach is to link up with private clinics who provide services for STDs and expand their capacity to do so. It however becomes difficult to increase access to the poor through this method and the more affluent would be going there anyway.
- Therefore the main approach remains making more public health facilities which provide this service. The optimal and most immediate solution is to make RTI/STD services available in every First Referral Units or Community Health Centre. This should be able to provide the full range of services. At the primary level also most of the problems which are simpler problems could be attended to. The problems of achieving this are:

  A) No woman doctor may be available: The best way forward and what has been done with success in some states is to have nurse practitioners. These are some nurses given an intensive training package to be able to deal with STIs/RTIs to the level of any MBBS doctor. They can do vaginal examination, and where needed take a biopsy /swab for testing etc. But the facility must have enough nurses to do so.

  B) The laboratory support may not be available: A simple laboratory kit and guide that can be used even in a primary health center is now available - but is not in wide use. At the CHC level there is a laboratory technician in place.

  C) The counseling skills and support are not available: One can train the nurse –practitioner but it may be useful to designate and work out a support package for an NGO for each block. They could provide the counselors, plus help in organising the IEC work, plus take roles like notifying

partners etc. They would however have to be trained and would need monitoring especially to ensure that they observe guidelines on confidentiality and must be professional social workers who can win the confidence of the community. The community may prefer to trust nurses for such a task. The scheme to train nurse practitioners has special relevance here.

D) Organising the clinic : In the CHC facility which has less patients as compared to a district hospital, a separate STD clinic may neither have the numbers or privacy needed to justify it. Often it would also have no STD specialist. It would therefore make it more useful to present it as a clinic for Gynecological morbidity – or simply Special Clinic for Women's Health problems with a gynecologist in charge and two trained nurses. Where there is no gynecologist a women doctor would be in charge and where there is no woman doctor, a nurse practitioner could be in charge. For younger girls a separate adolescent clinic would be attractive. Even nurses sitting in a room marked "for women's health diseases" and referred patients from the male doctors would make all the difference. For men, male doctors may treat them in the OPD itself . If there are too many patients and one is unable to find the time for counseling – the doctor can ask them to come back on a specified afternoon of the week for more detailed examination and for counseling.

Strategy 5: Reaching out to asymptomatic infections.

There are a number of situations where one can routinely test for RTIs and STDs. The most common is in pregnancy care – since asymptomatic infections have an adverse effect on the fetus or newborn. This can also be offered as a service for those who have willingly or forcibly been exposed to sexual intercourse and want to rule out infection. As general awareness increases a regular once a year gynecological check up becomes a desirable norm.

A third context of searching for asymptomatic infection is with the spouses of those with symptomatic infection. There is a need to call all of them, and examine and treat them for infection. Blind treatment is not preferred for examination may reveal more than one type of STD.

A fourth context of searching for asymptomatic infection is screening. At present no general population screening is advised though it may be taken up in high risk groups.

Strategy 6: Targeted Interventions

This refers to special emphasis on early detection and prompt treatment of STDs and other *RTIs* among high risk groups through targeted intervention projects. This is discussed along with the chapter on HIV control.

THE MANAGEMENT OF INFERTILITY

Introduction

Infertility is a major problem. Couples who want to have a child, are distressed by the lack of ability to bear a child and would require medical assistance. In addition in India, women are held responsible for infertility and it may lead to loss of status and even desertion and bigamy. The woman herself may be depressed by the experience. Fortunately adoption of children has become easier but to many families this is unacceptable and not an alterative to bearing a child. Moreover for poor families it is extremely difficult to adopt a child through a legal process.

According to the National Family Health Survey some 2% of the older women who should have normally completed child bearing do not have children. This could be one measure of infertility though women may opt not to have children for many other reasons. Other studies quote 2 to 5%. The rural Maharashtra study quotes 7%. And some estimates would put it as high as 10%.

Causes of Female Infertility are:

a) Pelvic Inflammatory Disease (often related to poor quality of reproductive care in the past like unsafe abortion or unhygienic conditions of delivery)
b) Some Sexually transmitted diseases.
c) Tumours/growths and abnormality in the uterus or genital tract.
d) Tuberculosis of the reproductive system.
e) Some viral infections like mumps
f) Hormonal causes.
g) Previous pelvic surgery or abortions
h) Use of IUCD
i) Thyroid disorders
j) Emotional stress

Causes of male infertility:

Male infertility seems to contribute to 50% of the situations of infertility and also, anecdotally, to be on the increase. This is being attributed to alcohol and nicotine abuse, occupational hazards, environmental toxins, other commonly prescribed medications such as cimetidine, nitrofurantoin and sulphasalazine, undiagnosed undescended testis and in some cases to childhood vaccine preventable diseases such as mumps. Essentially, male infertilty is due to lack of sperms or lack of effective sperms in the semen: Often the exact cause cannot be made out.

There is also a growing problem where family planning programmes are proceeding well despite high child mortalities that both children are lost and the family wants re-canalisation to regain fertility. Microscopic

tuboplasty is being used in India to reverse tubectomy with high success rates of post operative patency and about 50% success in subsequent pregnancy.

STRATEGIES

Again the approach is graded standard treatment protocols for different levels of the service.

- At the community health worker level, it is counseling for both husband and wife to seek treatment together and also to help the couple and especially the woman with the social problems of it.
- At the ANM /MPW(M) level, it is about safe and healthy sexual practices and how to maximise chances of conception by timing sexual intercourse at about the time of ovulation.
- At the level of the first referral unit one should be able to rule out male infertility if the laboratory assistant/medical officer can do a semen analysis. And one can also rule out some of the more basic causes of female infertility.

However in practice this would be difficult to establish and it would be preferable to focus on ensuring that infertility clinic services are available in all district hospitals with a gynecologist with some pathological and radiological back up.

Good BCC on infertility issues are advisable too, specially to clarify that the cause of infertility lies with men as often, if not more, as women.

Promotion of a center for infertility enhances its credibility for all obstetric and gynecological services. This is a lesson private clinics have now learnt and infertility treatment has become big business. But given the focus on the poor, it may be more useful to promote adoption and prevent infertility to some degree by recognising its links with the quality of reproductive services and prompt treatment of pelvic infections and other causes.

It should be remembered that infertility is a health issue with several social implications for women. Undoubtedly women do suffer emotional trauma if they are unable to bear children, but it is difficult to say how much of this results from their intense socialisation to fulfil the role of 'motherhood' and the lack of choices to women who may not themselves be too affected by not having them. Women who are unable to bear children are made to feel inferior, incomplete and guilty, and suffer mental and physical abuse at the hands of their families. They are at greater risk of abandonment and desertion at any time. They may also be subjected to all kinds of rational and irrational processes ranging from *jhaad phoonk* to many cycles of expensive, frustrating and risky assisted reproduction techniques. Thus, apart from being a health problem for women, the response to infertility can itself be a cause of great mental and physical ill health to women. This is yet another example of how patriarchal society stereotypes and manipulates women in the image of 'motherhood' to the exclusion of their rights as human beings.

THE PROVISION OF SAFE ABORTION SERVICES

Introduction

World-wide an estimated 46 million pregnancies end in induced abortion each year. Nearly 20 million of these are estimated to be unsafe.

About 8 per cent of pregnancy-related deaths have been attributed to complications of unsafe abortion, and probably number over 6000 deaths annually by a conservative government estimate.[3]

In India, the risk of death following complications of unsafe abortion procedures is several hundred times higher than that of an abortion performed professionally under safe conditions. Complications resulting from unsafe abortion contribute to serious sequels for women's health such as infertility and pelvic inflammatory disease.

- In almost all countries the law permits abortion to save the woman's life and in most countries abortion is allowed to preserve the physical and mental health of the woman.
- Many women and men either do not have access to appropriate contraceptive methods, or do not have adequate information and support to use them effectively.
- Since no contraceptive is 100 per cent effective, there will continue to be unwanted pregnancies which women may seek to end by induced abortion.

> *Safe abortion services, as provided by law, need to be available, provided by well-trained health personnel and supported by policies, regulations and a health systems infrastructure, including equipment and supplies, so that women can have rapid access to these services.*

What is unsafe abortion?

An unsafe abortion is "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" (World Health Organisation 1992).

Almost all the deaths and complications from unsafe abortion are preventable. Procedures and techniques for early induced abortion are simple and safe. When performed by trained health care providers with

3. Based on SRS data, 2004

proper equipment, correct technique and sanitary standards, abortion is one of the safest medical procedures. Properly provided services for early abortion save women's lives and avoid the often substantial costs of treating preventable complications of unsafe abortion in many circumstances where women are legally entitled to have an abortion.

Safe Services are not available for a range of reasons. These include:

- Health system problems such as a lack of trained providers or their concentration in urban areas
- Negative provider attitudes
- Use of inappropriate or outdated methods of inducing abortion
- Lack of authorisation for providers or facilities
- Lack of knowledge of the law or lack of application of the law by providers
- Lack of public information about the law and women's rights under the law
- Lack of awareness about facilities providing abortion or the need to obtain abortion early in pregnancy
- Family attitudes, stigmatisation and fears about privacy and confidentiality
- Poor quality of care provided, for safe and legal services

Making abortion safe and accessible to the full extent of the law requires training health personnel so that they are conversant with national laws and regulations as well as with technical procedures, ensuring equipment and supplies, and designing protocols, regulations and policies that promote access to quality abortion services.

KEY STRATEGY DIRECTIONS

1. Providers must be proficient in clinical skills required for high-quality abortion services, including diagnosis of pregnancy, provision of information and counseling, selection and provision of an appropriate abortion method based on its safety and efficacy, and care after abortion.

2. There should be a mechanism for certification and licensing, monitoring and evaluation, and financing to ensure that the national norms and standards are followed.

3. There is need to put good quality, legal abortion services in place after needs assessment so that there are no area gaps or no social groups which are unable to access these services.

Skills that are needed:

Methods of abortion

- Methods preferred for early (first trimester) abortion are manual or electric vacuum aspiration, for up to 12 completed weeks since the woman's last menstrual period.
- Medical method of abortion for up to 9 completed weeks since last menstrual period – a combination of mifepristone followed by a prostaglandin such as misoprostol or gemeprost. Misoprostol is the prostaglandin of choice for most settings since it is cheap and does not require refrigeration.

- Dilatation and curettage (D&C) should be used only where vacuum aspiration or medical methods of abortion are not available.
- For pregnancies of more than 12 completed weeks since the woman's last menstrual period, the methods preferred are dilatation and evacuation (D&E), using vacuum aspiration and forceps; and mifepristone followed by repeated doses of a prostaglandin such as misoprostol or gemeprost - Prostaglandins alone (misoprostol or gemeprost), in repeated doses.

A process called "Cervical preparation" is necessary before surgical abortion is done for durations of pregnancy over 9 completed weeks for nulliparous women, for women younger than 18 years old, and for all women with durations of pregnancy over 12 completed weeks.

Note that medical abortion requires multiple visits to the facility and extra vigilance to ensure that abortion has been complete and that there are no major side effects since it happens over a period of time and when the woman is at home. Therefore, it is not an appropriate choice if follow up facilities or patient motivation is poor.

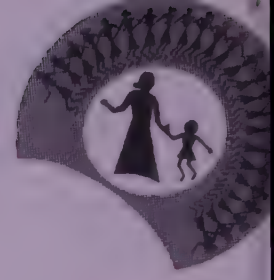
Additional Components

i. Pain management should always be offered.
ii. Choice of appropriate local anaesthesia.
iii. Universal precautions for infection control should be used, as with the care of all patients at all times, to reduce the risk of transmission of blood-borne infections including HIV.

Counseling and Information

At a minimum, a woman must be given information on:

- what will be done during and after the procedure
- what she is likely to experience (e.g. menstrual-like cramps, pain and bleeding)
- how long the procedure will take
- what pain management can be made available to her
- risks and complications associated with the method
- when she will be able to resume her normal activities, including sexual intercourse, and
- follow-up care.



Provision of Contraceptive and Safe Abortion Services at Various levels

Defining the set of contraceptive services and safe abortion services at various levels will be helpful fo the women to access these services. Of course, they must also be available!

There are often questions and confusions about whether a contradiction exists between legally an freely available abortion services, almost as a right of a pregnant woman, and the simultaneous curtailmen against sex selective abortion.

The box below explains why and how both these issues are different from each other.

Level of care	Provider	Provision of services
Community level	Community-based health workers	• Help women avoid unwanted pregnancy through providing information and contraceptives • Facilitate access to condoms and pills. • Inform them about the consequences of unsafe abortion. • Inform women how to obtain safe, legal abortion care without undue delay. • Refer women with complications of unsafe abortion for appropriate care.
Primary-care facility level	Nurses, midwives, health assistants, and, in some contexts, physicians	All the above with: • Manual Vacuum aspiration • Medical methods of abortion • IUD insertion
First referral level	Specialists, Trained Medical Officers	All the above offered on a regular basis, with: • D & C • Sterilisation Services for male and female patients (Mini-laparotomy) on regular basis. • Managing the complications of abortion. They should therefore be prepared to accept abortion-related referrals from health care facilities throughout the catchment area.
Secondary and tertiary referral hospitals	Specialists	Secondary and tertiary hospitals should have staff and facility capacity to provide wide range of contraceptive services and perform abortions in all circumstances permitted by law and to manage all complications of unsafe abortion.

Monitoring and Evaluation of Safe Abortion Services

Routine service statistics

- Numbers of abortions provided, by completed week of pregnancy and by type of procedure.
- Time between first consultation and abortion.
- Of women referred elsewhere, by reason.
- Number of women seen but not provided with services, by reason.
- Number of women treated for complications, by type of abortion procedure.
- Contraceptives provided, by type.
- Referrals for contraception.

Periodic evaluation

- Percentage of service delivery points offering abortion care, and their distribution by geographic area and level of the health care system, and patterns of utilisation.
- Number of providers performing abortion and their distribution by geographic area and level of the health system.
- Number of health workers trained, by type; assessment of quality of training.
- Assessment of quality of care provided.
- Costs of abortion services and of treating the complications of abortion, by type of procedure and type of provider, and any fees charged.
- Periodic special studies (client satisfaction, proximity of women to facilities, costs, impact, etc.)
- Number of staff needing in-service training and numbers trained.

Patient information (kept in patient file)

- Age, parity, marital status.
- Reason(s) for referral.
- Reason(s) for refusal.
- Follow-up care given.
- Contraceptive method chosen.
- Fee charged, if any.

MALIGNANCIES

Breast cancers and cervical cancers are the two most common cancers in women. These are both subject to complete cure if detected early, and unlike many other cancers it is actually possible to detect these cancers quite early. Cancer cervix is very much a largely preventable third world disease, related to poverty like many other infectious diseases and needs to be therefore prioritised in health planning.

We must note that cancer is the fifth most common cause of mortality in the 15 to 44 age group – more than maternal mortality!!

Cancers of the uterus, ovaries and vagina are less common and these are more difficult to detect very early.

SEX SELECTIVE ABORTION

Strong son preference has resulted in discrimination against girl children in India. The 1991 census reported a child sex ratio of 945 girls per 1000 boys in the 0-6 year age group, and this declined to 927 in the 2001 census. In states such as Haryana, Punjab, Delhi, and Gujarat, this ration has declined to less than 900 girls for every 1000 boys.

There are reasons to believe that it is increasingly becoming common practice across the country to determine the sex of an unborn child or foetus and eliminate it if the foetus is found to be a female. This trend is also strongly linked to the growing practice of dowry which results in a girl child being considered a great economic burden upon the family in the future.

In response to a strong advocacy effort, the Prenatal Diagnostic Techniques Act, The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (PNDT Act) was enacted in 1994 and amended in 2003 by the Government of India. The Act and Amendments provide for the regulation of the use of pre-natal diagnostic techniques (e.g. amniocentesis and ultrasonography) to detect genetic or metabolic disorders or chromosomal abnormalities. It has explicit provisions for the use, regulation and monitoring of ultrasound machines to curb their misuse for detection of the sex of the fetus. The Act prohibits determination and disclosure of the sex of fetus, as well as any form of advertising about facilities of pre-natal determination of sex.

In addition, the practice of female infanticide also continues in many parts of the country, Salem district in India being the most notorious. As an innovative intervention, the Tamil Nadu government has launched a program called the Cradle Baby Scheme to convince parents not to kill, but surrender unwanted baby girls to the state.

The use of technology and abortion for the purpose of pre birth elimination of females needs to be distinguished from women's right to abortion and the access to safe abortion services. It is sometimes argued that sex selective abortion should be allowed on grounds of personal choice since it reflects the real-life situation of the families in which girl children are being born. Doctors also justify it on the grounds that it is better for a fetus to die than allow a girl to be born and be discriminated against. however, we need to understand that while a fetus (the sex of which is unknown) can be aborted as per the Medical Termination of Pregnancy Act as the right of the woman who is pregnant, it is abortion on the grounds of sex that is illegal since it amounts to an attack on a whole section of society. As far as personal choice is concerned, society intervenes in many personal situations (by way of laws regarding domestic violence, or divorce, for example) where it is a case of protecting the rights of a weaker group and to take care of society's own larger interests. It is our social responsibility to make sure people are not compelled by social or economic considerations to commit illegal acts rather than justify the acts themselves. There should be no doubt; sex selective abortion is another manifestation of violence against women. Another matter for concern is that data from the 2001 census shows that most regions characterised by the adverse child sex ratio are the advanced regions of India in terms of higher capita income and literacy levels. Thus the driving force is more than economic.

Birth records at district level and below, including birth order are critically needed to assess the extent of sex selective abortions at the district level. Social movements at the grass roots are required in order to counter the trend of sex determination and sex selective abortions in which providers and the community are complicit partners. Regulations placed upon medical practitioners and ultrasound operators should be stringently enforced by district authorities; even a few cases of action against some prominent practitioners can send a strong signal for others to desist. Action for banning sex determination should be carefully planned so that Indian women can retain the right to access safe abortion and yet enabling a halt to sex selective abortions.

The key actions are:

AT THE COMMUNITY LEVEL:

- Awareness about the early signs of malignancy: Especially lump in breast or abnormal or bloody discharge per vagina – "even spotting just once" in the post menopausal age group
- Prompt referral where there is suspicion.

- Building up support for screening for breast cancer and cancer cervix in all women over 40 – at least all those who present for any gynecological problem.

AT THE PERIPHERAL FACILITY LEVEL:

- Building up awareness about early signs of malignancy.
- Asking for any symptoms indicative of malignancy from women who visit it.
- Examining all women above 40 for breast cancer and referring them for screening of cancer cervix if they have gynecological problems when they visit the health facility.

AT THE FIRST REFERRAL UNIT:

All the above plus laboratory back up especially for PAP smear (this is a simple test done through the vagina which requires a microscopic examination in a lab). There is a need to specify the level at which a PAP smear be taken and where it can be examined. Ideally all ANMs should be able to take a smear and all CHCs should be able to examine it.

AT THE DISTRICT HOSPITAL/SECONDARY HOSPITAL LEVEL:

All the above plus:

- Complete investigations at least for breast cancer and cancer cervix. Rest can be referred to tertiary care center.
- May consider surgery if in early enough stage – in synergy with a tertiary care center- especially if these is a long waiting period for surgery in the higher center.

I. Review Questions

1. What are the elements of Reproductive health other than care at pregnancy?
2. How do reproductive tract infections and sexually transmitted diseases overlap as gynecological diseases and in what ways are they distinct from each other?
3. What are the strategies to address RTIs?
4. Why is it important to address infertility?
5. What are techniques of abortion – and at what levels do each technique become available – as per recommendations?

II. Application questions

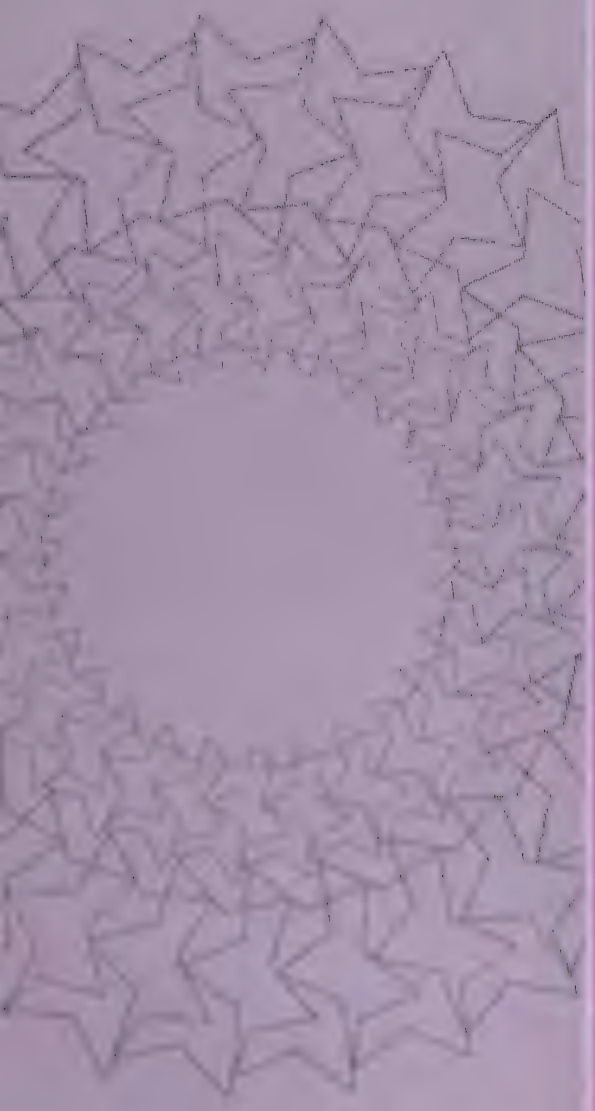
1. What part of gyecological illness (illness of the female reproductive system) is due to obstetric illness (related to childbirth)? What are the common types of obstetric morbidity? Can it be integrated into this lesson and into the district plan?
2. Why should we consider infertility clinics when adoption is available as an option? There are costly infertility clinics in the private sector where lakhs of rupees are spent for conception – what is your view on these.

III. Project Assignment

1. Write a situation analysis about the availability of abortion services in a block. Write up the section of the district plan that would plan for RTIs, STD clinics, safe abortion services and for infertility care for a specific district.
2. Devise a monitoring check list and monitoring plan for reviewing this plan on a quarterly basis.

Lesson FIVE

Population Stabilization and the District Plan



In this lesson we shall discuss:

- Dimensions of the problem
- Population policies of the past and their critique
- An understanding of why there is an increase in population
- Main features of National Population Policy 2000
- What the components of a district level population control plan are
- What the indicators of a district level population control plan are
- How a district level plan is made
- What the BCC focus of a population stabilisation programme are

INTRODUCTION

"On May 11, 2000 India is projected to have 1 billion (100 crore) people, i.e. 16 percent of the world's population on 2.4 percent of the globe's land area. If current trends continue, India may overtake China in 2045, to become the most populous country in the world. While global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crores) to 1 billion in the same period. India's current annual increase in population of 15.5 million is large enough to neutralise efforts to conserve the resource endowment and environment."[1]

In 1991, India's population was 846.3 million which rose to 1027.4 million 2001. In 2011 it is predicted to be 1178.9 million and 1263.5 million by 2016. Clearly this rapid growth of population is incompatible with development. Recognition of this problem dates back to the time of Independence.

POPULATION POLICIES OF THE PAST : A CRITICAL UNDERSTANDING

The Early Years

Seized with this problem, the Indian government was one of the first governments in the world to launch a National Family Planning Programme as early as 1952. The next three Five-years Plans, especially the Third Five-year Plan saw an increasing emphasis on population growth as the explanation for poverty asserting that a high population growth rate made it difficult to increase the rate of savings which was essential for higher productivity and incomes. At that time India's growth rate was peaking at over 2% (as compared to 1.38% in 2006) per year, and as incomes grew and consumption grew, and death rates fell, the country was plagued with scarcities.

The focus of the programme was first on the promotion of a small family norm and the welfare of women and children and the role of sex education and marriage counseling. But increasingly the focus shifted over these years to the promotion of contraception. As the IUD became universally available there was a shift to its widespread, supplemented by male and female sterilisation.

The Late Sixties and Seventies : Target-driven and Coercive

In the Fourth Five-year Plan with a declaration of a target driven approach the programme became almost completely and singularly the promotion of contraception – to the exclusion of all other dimensions not only of family planning but of health care. Part of the reason was the emerging technologies. In the late 1960s and the early 1970s the focus was on IUD insertion, and there were very large camps held to meet targets. Then from mid-70s to the end of the 70s the whole effort became the promotion of vasectomy. By then everyone, especially all heath functionaries and later almost all government functionaries, were

1. National Population Policy, 2000

being given quotas to fulfill. If each of them did not somehow manage to bring in a number of cases for vasectomy they were liable for disciplinary action. Its peak was reached during the emergency years of 1975-77 when sterilisation was made compulsory and many people were physically coerced into vasectomy camps where they would have the surgery done on them without their consent. One state even passed a bill to make this law, but before it could be implemented the government faced a massive electoral defeat – in great part due to this coercive family planning drive – and this entire policy was put on hold.

Throughout this period the birth rate continued to remain almost steady and even after such a heavy push declined only marginally. It was 45 per 1000 in 1941 and only 41 per 1000 in 1971 and still at 33 per 1000 in 1981 and 30 per 1000 in 1991.

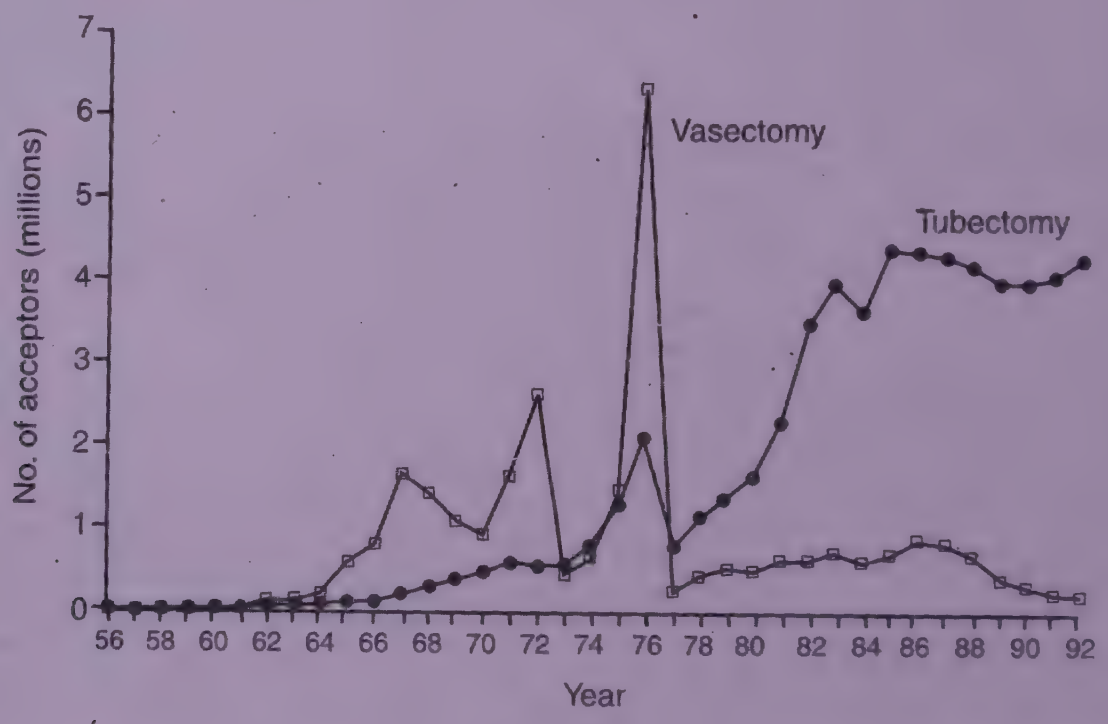


FIGURE 14.1 Acceptance of male and female sterilization : India, 1956-92
Source : GOI, MOHFW, Department of Family Welfare 1996, p. 140.

The Eighties: From Overt Coercion to Incentives and Disincentives

In 1978, forced by the electoral defeat, the policy shifted from family planning to family welfare – in concept, a focus on care in pregnancy and child care replacing the singular focus on contraception alone. In 1983, the new National Health Policy called for "securing the small family norm, through voluntary efforts and moving towards the goal of population stabilisation". It also set the target for reaching a net reproduction rate of 1.0, a total fertility rate of 2.1 and a couple protection rate of 60 by the year 2000.

In practice though coercion stopped, it still continued to be a camp driven approach – now the favoured intervention being almost exclusively tubectomies – and later laproscopic tubectomies. A system of

incentives and disincentives built around the two child norm came to be center stage in place of the overt coercion of the earlier period. Again, inter-state comparisons show no evidence that this works. Indeed the states that were doing well – Kerala firstly and then Tamil Nadu and later Andhra Pradesh, Himachal Pradesh etc. did not have much of these features in comparison to states like Madhya Pradesh or Maharashtra who were strong on the targeting approach and weak on the outcomes. Also child care expanded to include immunisation and maternal care started addressing ante-natal care – very often merely registration of pregnancy. Other dimensions of care continued to lag behind.

The Nineties : Shift to Reproductive and Child Health

It was in the 1990s that the emphasis really started shifting away from the targeted family planning focus to a more holistic coverage of maternal and child care. First with the Child Survival and Safe Motherhood Programme, and then with the Reproductive and Child Health Programme, the health strategies started addressing the full range of RCH services instead of only family planning. It was also now that targets were officially dropped.

Lessons from the Historical Review

Surveying the 50-year history of family planning work in India before the National Population Policy was adopted, most commentators reach the following conclusions:

1. That family planning was always considered an important goal- but as long as it was not linked to other elements of RCH, it was difficult to achieve progress in lowering fertility rates.
2. That at the policy level the government always accepted that maternal and child care should go along with contraception – but at the level of strategy, schemes that were drawn up only pushed contraception- that too by sterilisation.
3. That family planning occupied so much of the space and time of the health department that it distorted the way the department and all its institutions grew. Even the perception of the health workers of their main task was such that primary health care as a goal got pushed behind.
4. That one of the problems with the target based approach was that invariably targets would be achieved but programme outcomes would not be realised. Thus the early IUD insertion campaigns inserted more IUDs than the targets, the vasectomy campaigns exceeded their quotas and the tubectomy targets were always met – but the corresponding decrease in fertility did not occur.
5. That increasingly the emphasis shifted to only those approaches where women had to be made to accept sterilisation- and the emphasis on involving men decreased further. Also in the camp based approach, there were complaints of lack of basic dignity in the way women were treated in these over crowded camps and of numerous deaths and failures of contraception due to these poor quality sterilisation camps. Thus the population programme came to be seen as a programme of "targeted sterilisation" which was viewed by many sections as an attack on women.
6. That because of all the above factors the government committed to a "Target-Free Approach (TFA) " where henceforth the emphasis would be on a voluntary choice of one from a number of contraceptive choices made available to them, based on their own felt needs for such services.
7. That though population was projected as the main cause of poverty so powerfully that most people believe it to be so, in reality population growth is more a consequence of poverty.

THEN WHY DOES POPULATION INCREASE?

Much of the earlier publicity material on the population campaign portrays the main cause of the increasing population as a behavioral problem of the poor. "The ignorant poor, unable to control their sexual impulses continue to breed even though so many more mouths to feed would ruin them. For them life is cheap." It did not occur to many that the poor could be making a rational decision or that large families are forced on them by circumstances. From this lack of understanding comes the need to provide incentives or penalties–to punish them "for they know not what they do" and "understand only this language". Though many people now see the forced sterilisation of the 1975-77 period as a mistake – they only see it as a tactical mistake- to have forced it in such a way as to allow such a reaction. They do not yet see that such targeting was both unnecessary and wrong.

What are the causes of the high rates of growth of population?

I. Poverty causes population increase :

"Development is the best contraceptive." This was a phrase proposed in the World Conference on Population in Bucharest in 1984. What does it mean?

To the family living in poverty, children are their only savings and their investment for the future in old age or if disability strikes. It does not cost much to rear a child in a poor household. And the child starts earning soon. The mother does not enjoy bearing more children. She simply has to.

The middle class salaried employee may have built his own house and have a pension to take care of him and accident benefits and old age care. But to the poor there is today no social security. All the developed countries of the world where there is universal social security were amongst the first to have controlled their population growth. Most developed countries have a problem-inadequate population growth! Where there is adequate social security they are also giving incentives for families to have more children.

Measures that address poverty and increase social security lead to lower fertility.

II. Patriarchy causes population increase :

Across the world, studies have shown that women "desire" to have only two or three children, especially if they have a reasonable chance that they would live. But seldom is the choice theirs. Men make the decision.

Women's education: An educated woman has the confidence and the skills to negotiate her sexual relationships with her spouse and the family size she wants. But this could be more of a problem for the less educated. Family sizes positively co-relate closely with the level of women's education. And in most states the number of educated women is only about half the number of educated men.

Age of marriage: About 50% of women are married before the age of 18 years. This is not just a cultural phenomenon- it is essentially a patriarchal phenomenon. Having a girl past puberty in her parental home is seen as a danger for she may exercise her own rights on her sexuality – and on choice of her partner. She has to be married off at the earliest. And almost always the girl is not consulted. One of the most effective ways to prevent early marriage is to keep them in school longer. If the age of marriage is pushed forward beyond 20 that alone would significantly reduce fertility rates.

Decision to space: Even if marriage is early and even where it is not the delay of the first child, the spacing for the second are important felt needs of most women. About 33% of all births have less than 2 years interval since the earlier birth. However temporary methods, especially the use of a condom, require the cooperation of the male and a mature understanding and development of ones sexuality. In the prevailing patriarchal mindset, the women cannot talk about sexual practice, and often her consent is not needed or cared for. There is thus no scope to negotiate condom use. The other methods of pill cannot be used for spacing due to its interference with lactation and is not a preferred choice for a woman who has never been pregnant. The IUD is a choice but getting the service is difficult and its side effects could be high, and again male cooperation is needed for accessing the service. Patriarchy constrains male participation and the absence of male participation thus almost rules out the possibility of spacing.

Son Preference: The desire for a male child is at the root of many large families. This is particularly true of families where otherwise the two child norm has caught on. This is the last bastion against the two child norm, but it would not be easy to go. If the first two children are girls the attempt for the next to be a boy leads to either a larger family size – or what is even more unacceptable – to sex selective abortion or female infanticide. This is one of the problems of pushing a two child norm coercively – it justifies and leads to an increase in the latter. People particularly in village areas desire to have more sons to ensure the masculine capacity of the family to protect their property.

As a result we can conclude- whenever the situation of gender equality is better and women's education and empowerment is more the family size comes down by itself.

III. High Infant Mortality causes large families!

To guarantee a surviving male child, a poor family needs to have many children. The fear of children dying means the necessity to bear more. One estimate puts it at an average of 6 to 7 children per mother to have a 90% chance of one surviving male child when she is in her old age, given an IMR near 90 to 100. The mother feels terrible agony and helplessness and guilt when faced with each child's death. The feeling that she could not protect and save what was given to her, what she loved most. And yet she has to go through the process again for she must have enough children- the family depends on it and her own status depends on it. Assist a mother to protect the child, let the family perceive a greater likelihood of child survival and the family size starts coming down. (There could be a lag between the two when the birth rate goes up initially).

IV. Lack of access to family planning services and information

Despite the fact that there was a time when over half the health budget went to family planning, there are still many villages where women still have no information about condoms or pills. And in most villages access to contraceptives is still a huge problem- even when they are willing to pay for them! Though there are a lot of social marketing firms on the scene, most of them do not extend beyond the small towns and big villages. The depot holder is usually a dominant male and there is no chance of the poor household being able to convey their sexuality related needs to him. The ANM is more acceptable for this role – but she would be rarely seen in the village. The Anganwadi Worker or ASHA would be an option – but for some of the villages only and anyway they seldom have adequate stocks.

Availability of sterilisation services has always been poor and now there are reasons to believe that it has worsened. In most blocks of the country the situation is, as an ANM in one of the eastern says, *"the sterilisation camp occurs on three or four days of the year. Sometimes it is even less. Which day it occurs is fairly unpredictable- not even I know till that month. And then I have to pass information to all the hamlets. There are many women waiting their turn – but they have to be free on that day, and if their periods are due, or if there is any doubt that they are pregnant they may be refused. Sometimes they go, only to find that the doctor had not turned up and it is a wasted day. Since there are approximately 1000 couples in that 1 lakh population who not only need the tubectomy but are also willing for the surgery, one does not inform all as a huge rush turns up and everyone cannot be catered to. Arrangements are made for about 100 women but over 200 could turn up – and one has often to inform the police to keep law and order. By rule only 20 cases can be done per day and if the surgeon is 'not very cooperative' he would refuse to do more cases and then it could be very confusing. I cannot decide who has the priority and the result is that everyone is angry with me. I therefore always take a bit less than my allotted quota. Yes, I stick to quota- but I could easily do more."*

Many reasons lie behind such a situation. The number of trained laparoscopic surgeons are few. One must have a degree in gynaecology and obstetrics to be allowed to do this surgery and such people are few in the districts. Many of those so trained find it boring and demeaning to come and do this surgery repetitively. They also do not like to operate in the camp-like environs. They therefore avoid coming. Those who come find that there are not enough laparoscopes to make full use of the time. Ideally there should be three per surgeon. One would be what most are able to obtain. Laparoscopes are costly and often under repair. There is a long time in procurement and an equally long time to repair.

Conventional tubectomy requires two days of hospitalisation. Also since it is not being done, many have lost the skills.

Vasectomy is easy to do, but there is reluctance for men to come forward to get this procedure done and in anticipation of this reluctance many centers do not even try.

The net result is that despite so much publicity, the truth of the matter is that there is a huge unmet need and indeed it is more correct to talk of an "unmet demand" for this surgery. A number of women are becoming pregnant while awaiting their turn for sterilisation services.

An early estimate of what part of the births are contributed by women in this group with unmet needs, was 20%. This has possibly increased as more and more girls complete 8 years of schooling. Repeated surveys have shown that when women are asked how many children they desire to have most report only two or three. The challenge is now not in promoting the small family norm but in enabling it.

While families await permanent methods of contraception they could have used condoms or pills or even IUD and this is becoming now the main context of usage of temporary methods. But as we already noted, there are so many problems in access and use of temporary methods that fertility rates continue to remain high.

In 1941 birth rate was 45 per 1000, falling to 41 per 1000 in 1970, to 33 per 1000 in 1981 & 30 per 1000 in 1991. The country was to have reached a birth rate of 25 per 1000 by 1984. It was to have achieved a net reproduction rate of 1 by the year 2000 – or a TFR of 2.1. It did not. The National Population Policy adopted in the year 2000 has set these same targets again – for the year 2010, and NRHM adopted in the year 2006 has set these targets for the year 2012.

NATIONAL POPULATION POLICY 2000

The National Population Policy 2000 is a clear and modern enunciation of the national policy on population stabilisation. Since this policy was made after considerable discussions at every level and in the light of the understandings that emerged from the International Conference of Population and Development (ICPD) held in Cairo in the 1994, this policy has considerable depth of understanding and clarity.

To quote from the Policy:

> *"Stabilising population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health care accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communications.*
>
> *The **National Population Policy**, 2000 (NPP 2000) affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services.*

The NPP 2000 provides a policy framework for advancing goals and prioritising strategies during the next decade, to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels (TFR) by 2010. It is based upon the need to simultaneously address issues of child survival, maternal health, and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child heath services by government, industry and the voluntary non-government sector, working in partnership.

*The **immediate objective** of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The **medium-term objective** is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The **long-term objective** is to achieve a stable **population** by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection."*

Components of a District Population Control Plan[2]

The minimum components of a district population control programme would be:

1. Strategies for retaining girls in school (Universal Elementary Education and beyond) i.e Increasing educational levels in women
2. Strategies to delay age of marriage
3. Strategies to address son preference
4. Improving child survival
5. Improving care in Pregnancy
6. An effective adolescent health care programme
7. Improving access to treatments for RTI/STI
8. Improving access to safe abortion services
9. Planning Behaviour Change Communication (including promotion of male participation)
10. Planning for Efficient Provision of Contraceptive Services

INDICATORS[3]

The indicators used to measure the progress in population stabilisation programmes are:

Age Specific Fertility Rate

(No. of live births at a specific age of mother / No. of women at the specific year of age) * 1000

It is expressed as per thousand women of specific age group in years per year. It is higher below 30

2. Dr Alok Ranjan, Dr Ishwar Dass, Decentralised Planning for Population Stabilization: Population Resource Center, Madhya Pradesh,2005
3. Source for indicators- Park K., Park's text book of Preventive and Social Medicine, 16 edition ;2000.

years of age. In practice five yearly age group from 15-19 years to 40-44 years, total six groups are considered in 30 years of reproductive age. It gives an idea in which age group fecundity/fertility is more and where in the CPR (Couple Protection Rate) should be raised. It is one of the more sensitive indicators of family planning achievement.

Total Fertility Rate (TFR)

It indicates the number of children likely to be borne to a mother.

It is computed by adding up the annual age specific fertility rates, usually six groups in number (from 15-19 to 40-44 year, in five yearly groups) and expressed as per woman.

This is the most commonly used fertility indicator and the goal is to bring it down to 2.1 by the year 2010. NFHS-III (reference year: 2005-06) reports it at 2.7 currently.

Gross Reproduction Rate

TFR * No. of female births / Total no. of births

It is expressed as average number of girls per woman. Here it is presumed that she completes her total reproductive span, without dying, at current rate of fertility. The total fertility rate corrected by ratio of female births to total births gives future perspective of population growth. The presumption of successful completion of reproductive span without death and current fertility throughout is not sound here.

Net Reproduction Rate (NRR)

The NRR is similar to gross reproduction rate. However at each age in reproductive age group the current fertility and mortality rates are assumed to be experienced by a newborn girl and then estimate is made how many female children she will bear. Here an allowance for mortality experience is made; however, the presumption about fertility rate is unchanged. This is a measure of extent to which mothers produce female infants who survive to replace them. NRR of 1 means the female population is maintained exactly and population size remains more or less constant or equivalent to attaining approximately the 2 child norm. The goal of NRR of 1 is the national goal of population stabilsation.

Crude Birth Rate

BR= Number of Birth in an area in a year/ Mid-year population of that area in that year * 1000

It is expressed as births per thousand mid-year population per year. The denominator includes population not exposed to child bearing. There are disadvantages with this indicator but it remains the most easily calculated and understood indicator – which can be calculated easily for the district level also.

The birth rate for the country is 24.1 in the year 2004 (SRS 2006).

Eligible Couple

An eligible couple refers to a currently married couple wherein the wife is in the reproductive age, which is generally assumed to lie in between the ages of 15-45. There will be at least 150-180 such couple per 1000 population in India.

Contraceptive Prevalence Rate

Contraceptive prevalence rate is the percentage of women between 15-49 years who are practicing, or whose sexual partners are practicing, any form of contraception. The indicator is useful in tracking progress in family planning. It also serves as a proxy measure of access to reproductive health services that are essential for meeting of public health goals, especially the child and maternal mortality. Household surveys, Demographic and Health Surveys, Contraceptive Prevalence surveys and Eligible couple survey yield this data. Estimates can also be made from service statistics using census projections as a denominator.

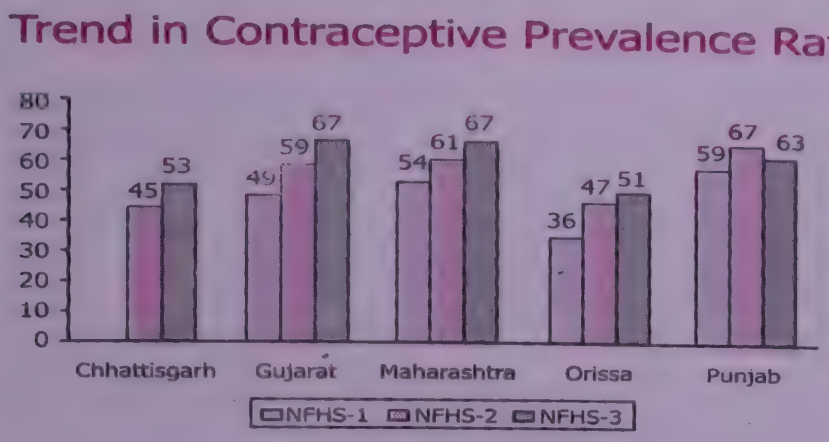
Couple Protection Rate (CPR)

It is an indicator of the prevalence of contraceptive practice in the community. It is defined as the percent of eligible couples effectively protected against childbirth by one or the other approved method of family planning, viz. sterilisation, IUD, Condom or oral pills.

Indicator	NFHS-II (All-India)
Total Fertility Rate (for past 3 years) (%)	2.85
Contraceptive prevalence rate (CPR)* (DLHS 2002-2004)	53.0
Current Contraceptive Use Any method (%)	48.2

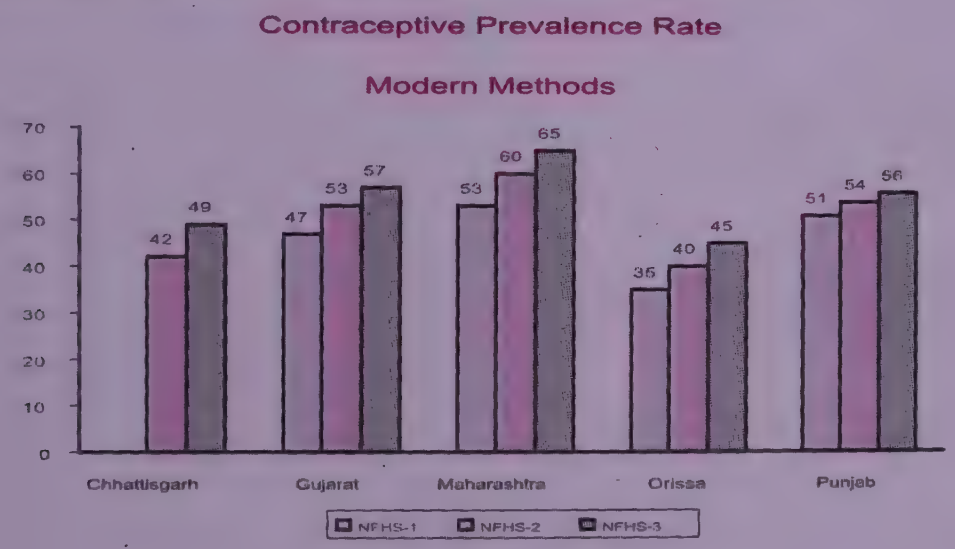
Source: National Family Health Survey–II, 1998-99; District Level Household Survey (DLHS), Reproductive Child Health, 2002-2004.

Demography goal of NRR=1 can be achieved only if the CPR exceeds 60 percent.

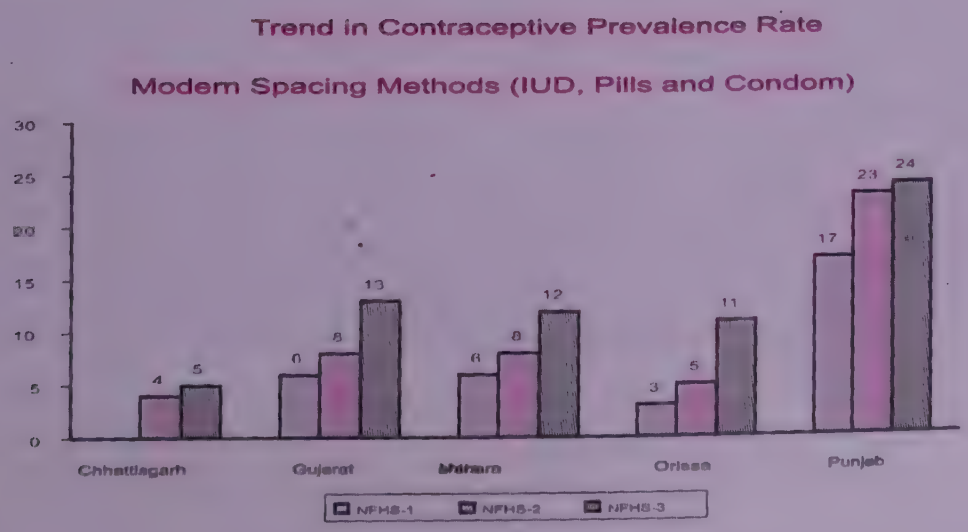


CPR for sterilisation: This is the index of CPR where we are measuring those couples protected by sterilisation only.

CPR for any modern method: Sterilisation or temporary contraceptives:



CPR for temporary method:



SUGGESTED INDICATORS FOR USE IN THE DISTRICT PROGRAMME

The earlier indicators were outcome indicators of a population stabilisation programme. But we also want to know progress achieved in each of the strategies suggested above for population stabilisation. Each of the above activities would have indicators, some of which are suggested below:

Indicator	Means of Verification
i) Planning for Higher Educational Levels in Women:	
a. Female literacy rate:	Census, sample survey during CNA (community needs assessment)
b. Girls in 8th class as percentage of those who enrolled in year 1	School records
c. Percentage of 14 to 18 girls who have completed 8 years of schooling:	Sample survey during CNA
ii) Planning to Postpone Age of Marriage:	
a. Number of girls who were married below 18 years old expressed as percentage of total number of girls marriages in the last year:	Marriage registration records, sample survey during CNA
b. Number of marriages registered with village authority/marriage registrar.	Marriage registration records
iii) Planning to Address Son Preference:	
a. Sex ratio at birth.	Birth records of ANM/Kotwar
b. % of families with two or more girls who are adopting/ willing to adopted/willing to adopt sterilisation.	CNA
c. % of families with two or more girls to two or more boys .	CNA
iv) Improving Child Survival.	
a. Infant deaths in last one year	Sample survey
b. Under 5 deaths in last one year	Sample survey
c. Child Malnutrition Rate	AWW records
v) Improving Care in Pregnancy.	
a. % mother received full Essential ANC	ANM
b. % of deliveries who had skilled birth attendance or institutional delivery.	ANM records/sample survey during CNA
vi) Improving Maternal Care	
a. No.of maternal deaths	ANM

Indicator	Means of Verification
vii) An effective adolescent health care programme	
a. % of adolescents who have received counseling	Records of clinics
b. % of adolescents aware of HIV/AIDS and condom/pill use	Sample survey
c. percent of adolescent girls with anemia.	Sample survey
viii) Improving access to treatments for RTI/STI:	
a. No. of women who had any complaint of	Sample survey
b. % of women with RTI/STI complaints who sought treatment.	Sample survey
ix) Improving access to safe abortion services:	
a. Total abortions done last year in all facilities accredited for the same.	Hospital records
x) Planning Behaviour Change Communication (including promotion of male participation):	
a. % of eligible couples having knowledge of temporary methods- what is available and where:	Sample survey
b. % of eligible couples, who are using or willing to use any temporary method.	Sample survey
c. Gap between CNA measured demand for any services and demographic requirement to reach goals	CNA and demographic requirement estimated by Bongaarts method (see below)
xi) Planning for Efficient Provision of Contraceptive Services:	
a. CPR by any method	CAN
b. CPR by temporary method.	CAN
c. CPR by sterilization.	CAN

1. Planning the Activities

Community Needs Assessment (CNA)

This is central to the entire planning effort. In essence this requires a household survey of every household done in the month of April and May each year by the staff of the Sub-center to:

a) update all her registers - as regards children, pregnancy, current and past outcomes
b) update in particular the register of every eligible couple
c) note their current use of contraception method
d) note their stated desired use of contraception by method.

The data is then classified and put into two tables - one that denotes current use and another that denotes desire to use. Those couples who have had sterilisation done need not figure in the second table – but those who are using temporary methods would figure.

Then the data from each Sub-center is consolidated for each block and this is used as the basis for planning at the block level.

Each Sub-center has about 700 to 1000 families under its jurisdiction and it can take one to two months to cover all the families. And another month to fill in gaps and consolidate data. Not all families have eligible couples. About 25 families can be covered in a day and in a week about 100 families can be covered easily - especially if it is done along with counseling. In some weeks when work is done on all six days and much travel is not involved one can cover many more families. But at each household the work should keep them for only about 15 minutes. If too much counseling gets combined – it would not be possible to cover all houses.

The supervisor must back check at least 10% of the households during the next month and identify and close gaps. This is needed not only for population control – this is the basis of organisation of all Sub-center activities.

Data consolidation of the village or the block reads like is shown in the two tables:

Form 3 : Number of those already using any contraception

Name of District | Name of Sector

Name of Block | Name of Sub-Centre

No.	Name of Village	Classification of Eligible couples	No. of Eligible couples	Method of Family Planning adopted									Total no. of sterilization	Others	Total
				OP	CC	IUD	Sterilization								
							Male Sterilization			Female Sterilization					
							General	NSVT	Total	General	LTT	Total			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
		No. of children on the basis of live births	0 child												
			1 child												
			2 child												
			3 child												
			> 3 children												
			Total												
		Classification on the basis of Age of wife	<18 years												
			18-21 years												
			20-30 years												
			31-35 years												
			35 years												
			Total												

Form 4: Unmet Demand (Need - as those who voluntarily want the services)

Name of District | Name of Sector

Name of Block | Name of Sub-Centre

No.	Name of Village	Classification of Target couples	No. of Target Couple	The actual need/desire of those who are not adopting family planning at present											Doesn't want family planning
							Sterilization						Total sterilization	Total	
							Male Sterilization			Female Sterilization					
				OP	CC	IUD	General	NSVT	Total	General	LTT	Total			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
		No. of children on the basis of live births	0 child												
			1 child												
			2 child												
			3 child												
			> 3 children												
			Total												
		Classification on the basis of Age of wife	<18 years												
			18-21 years												
			20-30 years												
			31-35 years												
			35 years												
			Total												

From these tables we now know the number of eligible couples who:

1. Want to delay the first child / Already delaying the first child :
   a. Using Condoms.
   b. Using Pills.

2. Want to space the second /Already spacing the second
   a. Using IUD
   b. Using Condoms

3. Are waiting for sterilisation not using spacing method.

4. Are waiting for sterilisation /Already waiting for sterilisation
   a. Using Condoms
   b. Using Pills
   c. Using IUDs

5. Are already sterilised

Once we have the above chart we have a measure of the total coverage as of now and the total services needed – all as per their own stated needs. We know this for each Sub-center area and for each block- the two units in which this is calculated. Gram Panchayats and village committees can be disaggregated and told their figures from the Sub-center.

We then need to compare this total potential need or requirement for services with total felt need or demand for services.

2. How to estimate the requirements

There are two ways of estimating total requirements:

a) from the CNA itself
b) from the Bongaarts method.

From the CNA :

The number of eligible couples who have completed their desired family size – and who have still not adopted a permanent method are the potential candidates for sterilisation. It would be helpful to have two separate figures – number of women who have had three children or more and are not sterilised, and number of women who have had two children and not sterilised as the two key figures to decide on sterilisation priorities. Both these figures emerge from the CNA process.

Compare this with the number who state that they want sterilisation. If the gap is large we have a service delivery side problem to address for sterilisation services.

To the above, add the number of women who have married within the last two years or have had children within the last three years and do not use temporary methods. These would certainly require temporary methods- though there would be many outside these two groups also who would require temporary methods. Also add in at least six months of temporary methods for all who state they want sterilisation if we do not have a fixed day per week or per month.

Compare this figure with the figure in CNA which states they want any temporary method. If the former figure is much larger then we can assume that we are addressing only a small part of the demand!!

Bongaarts Method[4]

Bongaart put forward a general formula that

$TFR = C_m * C_c * C_a * C_i * TF$:

Where TFR = Total fertility rate. This can be taken as 2.1 if we want to calculate the desired couple protection rate. Or we can calculate the expected TFR from the measured couple protection rate.

TF= Total Fecundity Rate= a rate that is more or less constant across populations and is taken as *15.3 births per woman*- the maximum possible biological fertility.

Cm= The index of marriage- assumption that sexual reproductive life begins with marriage=relates to proportion of women in the reproductive age who are currently married.

Cc=The index of contraceptive usage= relates to the proportion of women in the reproductive age who are currently using contraceptives.

Ca= the index of induced abortion= relates to the proportion of women in the reproductive age who had an induced abortion in the last year.

Ci= the index of fertility inhibiting effect of breastfeeding (lactational amenorrhoea)= the proportion of women in the reproductive age who are currently breastfeeding (measured from the mean duration of breastfeeding).

If we want a TFR decline to let us say 2.4 from 2.6 then we can estimate the couple protection rate we need to arrive at and apportion that amount within different groups.

Though sound methodogically – it may be simpler for local planners to understand the factors that immediately impact on fertility rates and act on it then plan backwards from the demographic requirements. Still this is interesting to know.

3. Fertility reduction approaches when contraceptive use by community needs assessment falls short of demographic requirements to stabilise population

The approach would be to focus on all the factors other than access to contraception. These are: more women's education, later age of marriage and age at birth of first child, improved child survival, improved care at pregnancy and child birth and safe abortion services and other women's health services, an effective adolescent health care programme and a strengthening with proper audience segmentation of the BCC campaign.

---

1. Bongaarts J (1978). A framework for analyzing the proximate determinants of fertility. *Population and Development Review*,4(1):105-132.

All these factors act on the demand side of promotion of contraception and the reduction of fertility. Also, even though the problem of unmet demand is high, since the goal is of lowering TFR to 2.1 and most states are well above it, we need to address these proximate factors in parallel to improving contraceptive access.

Most important most of these so called proximate factors are greater felt needs of the people and human rights issues in themselves and therefore achieving them is more than a tool to achieve a desired fertility rate- it is an end in itself.

4. Improving Women's Educational Level

This is of course the responsibility more of the department of education – but since the context is of a district plan – it is primarily a task that needs to be flagged under the inter-sectoral area and followed up by the district administration.

In some districts the challenge would be of reaching universal enrolment in schools.

In other districts the challenge is of ensuring that all children complete up to the 5th class - since there is now a functional primary school in all villages. This requires both the prevention of dropouts and attainment of at least fluent literacy.

In many districts this has been achieved – the goal now is universal elementary education that – all children reach the 8th class. A large number of girls drop out between the primary and middle school since there is no middle school in the village. Therefore there is need to create more middle schools and find ways of transport for children, including rural school buses or making free bus passes available.

This is even more of a problem when we want to extend education for all upto the 10th class when a girl would be 15 or 16 years old and till the 12th class when she would have reached 18 – and which would be our goal. In the southern states where universal elementary education is near 80% achieved already, the goal has shifted to reaching all girls till the 12th class. This latter also requires vocational streams to make it more relevant.

5. Pushing back age of marriage

This requires considerable systematic inter-sectoral efforts. The key components of these are:

a. Make for compulsory registration of all marriages. To facilitate it this should shift to the Gram Panchayat along with birth and death registration. This should be a Gram Panchayat function but supported by ANMs, AWWs, kotwars and ASHAs.
b. Bring an inter personal hamlet level and family level campaign to bear on this issue. Empower women's committees and ASHAs to learn to negotiate this and create pressure on this issue.

Support this campaign by high visibility BCC, so that a favourable environment for this is created. This would be an activity largely for ASHA, women's health committees and women's self help groups activity.

c. Let the district administration have a clear mapping of communities and areas where the problem is greatest. A process of negotiation and persuasion can then be used, backed by the coercive possibilities of early marriage being illegal. Sarpanches and local leaders should be called upon for support and participation. This would be largely a Panchayat function supervised and driven by the district/block administration.
d. Bring a pointed school based campaign on this focusing on the 6th class, or 8th class or 10th class depending on which level the problem is in the district. Children in the 8th class – both boys and girls should have adequate understanding of the issues involved and some ideas on how to negotiate and protect themselves. School teacher training and motivation for this is crucial.
e. Where the marriage has taken place, campaign for a delay in consummation and use this campaign to also negotiate with the groom for use of temporary contraceptives. This would be primarily a function of the sub-center and its staff.
f. This entire effort needs to be focused and therefore the use of village-wise indicators shown above to identify the areas and communities where the problem is maximal would go a long way to improve effectiveness

6. Addressing Son Preference

Son-preference refers to the desire of families to have a son in preference to a daughter. This particular manifestation of gender inequity is driven by economic, social and cultural considerations – but all of these are problems for development and equity. Son preference not only leads to an imbalance in the sex ratio – it is also a major contributor to large family sizes.

There are three major approaches to addressing this in the district plan:

- Awareness campaign
- Reward and incentive schemes
- Enforcing legal measures

Anti son-preference awareness campaign. In this, it is the ASHAs, the women's health committees, the self help groups and the women's organisations that have to play a leadership role. Other democratic organisations and youth groups and even political and religious forums need to be roped in. Many of the groups who worked in literacy campaigns would be able to do a good job of this. The use of songs, radio programmes and TV slots would help build up a favourable environment.

Addressing son-preference, and its manifestations in the phenomenon of female foeticide/ infanticide and sex-selective abortion bring the whole issue of gender equity into public consciousness. Population stabilisation implies stabilisation with the right sex-ratio!

***Incentives and rewards*:** The introduction of an incentive for a family with two girls to adopt family planning methods in the form of some social security or reward provision would be useful in the context for doing a major inter-personal communication effort by trained counselors.

Legal measures: One also needs to use a carrot and stick approach to health care providers. Encourage them to talk against son preference as a social duty while one waves the PNDT act to doctors who are complicit in sex selective abortion. This is discussed in some detail in Book 13.

Also focus the weight of the law on female infanticide which is still widespread amongst certain communities by exposing the barbarity of the way in which it is done and making a few well publicised post mortems of dead babies and then arrests of patriarchs in the affected area who are complicit in the killing. (This is tough, but let us see the district administrator rise to this challenge instead of picking on some dalit woman with three children and disenfranchising her after she has managed to win an election- which many of them were all too willing to do in the name of upholding the law.).

Does this contribute to population control? These practices may be wrong on moral grounds – but why place it in a chapter on population control?

Female feticide and sex selective abortion are one of the most extreme manifestation of patriarchal values – and as we saw, patriarchy is a major contributor to large families. Tackling it here – even with limited success – makes it easier to bring up the whole issue of gender equity into public consciousness. Issues like more choice for women, more education for women etc. are closely linked to the status of women in that community and how the girl child is to be brought up. Also population stabilisation implies stabilisation with the right sex ratio.

7. Improving Child Survival

This has been discussed in considerable detail in Book 3. Here we only note one dimension – that of duration of breastfeeding.

It is important to try for breastfeeding up to 2 years as it provides some degree of protection from pregnancy. Lactational amenorrhoea usually lasts six months and even though periods resume at six months, the chances of conception remain low as long as breast feeding continues. However there is still enough possibility of conception and if sexual intercourse resumes as early as two months after child birth, there is a need to use a contraceptive method. Breastfeeding is as good as combined contraceptive pills (about 2% failure rate) if *all* the following conditions apply (no exceptions):

1. The baby is younger than 6 months

2. The mother has not yet had a normal menstrual period
3. The baby is exclusively breastfeeding (or near exclusively)
4. There is no prolonged period (greater than 6 hours) when the baby does not nurse.

Working women may find it a struggle to breastfeed after the first six months and may have to stop by one year. Yet working conditions should be so created that she could continue at least until two years. Women who have never breast-fed are at much higher risk for conception once sexual intercourse resumes.

8. Improving Care in Pregnancy

This helps the woman and makes her confident and respect the health care facility. It also leads to a much better child survival. Improving care in pregnancy is discussed in some detail in Book 2.

9. An effective adolescent health care programme

The National Population Policy 2000 states "Adolescents represent about a fifth of India's population. The needs of adolescents, including protection from unwanted pregnancies and sexually transmitted diseases (STD), have not been specifically addressed in the past. Programmes should encourage delayed marriage and child-bearing, and education of adolescents about the risks of unprotected sex. Reproductive health services for adolescent girls and boys are especially significant in rural India, where adolescent marriage and pregnancy are widely prevalent. Their special requirements comprise information, counseling, population education, and making contraceptive services accessible and affordable, providing food supplements and nutritional services through the ICDS, and enforcing the Child Marriage Restraint Act, 1976."

Operational strategies are described in some detail in the Lesson 8.

10. Improving access to treatments for RTI/STI

This has been discussed in some detail in Lesson 6 earlier in the Book.

11. Improving access to safe abortion services

This has been discussed in some detail in Lesson 6 earlier.

PLANNING BEHAVIOUR CHANGE COMMUNICATION (BCC)

The "behaviors" that we need to address are broadly relate to:

- The proximate social determinants, as outlined above
- The acceptability, skills and appropriate choice and use of contraception
- Male participation in population control

The need is to look at the determinants of behaviour in each audience segment, then devise the appropriate mix of messages, media and communicator and then plan for the activities and use indicators to evaluate the outcomes. The general approach to BCC is described in some detail in Book 5.

Though a lot of BCC has taken place and continues to take place in the area of population control almost none of it has the sort of focus that we talk about. Here are a few in-use and potential messages:

Some In-Use and Potential BCC Messages

- *Population Explosion- Threat to the nation.*
- *More than three children increases the threat of maternal mortlity in subsequent pregnancies.*
- *Too many children are too many mouths to feed.*
- *You can have the power – to have babies only when you are ready for it – and to limit how many you have. Meet the ANM for more information.*
- *Pregnancy in the teens – a threat to life of mother and child – and a shame to society.*
- *I have two educated daughters. And in my old age they take better care of me – then so many other families who have had sons!!*
- *"Son or daughter- I am happy with both. Let it be of normal weight and healthy"...Pregnant woman talking.*
- *Delay the first, space the second, stop the third.*
- *"I could plan and ensure at least four years gap between two children. And both are healthy for I could take better care of them."*
- *"One child after another within two years is a threat to my life. The ANM told me how to delay the next till I am ready for it."*
- *Condoms and contraceptive pills are available in every anganwadi, and with every ASHA, in every sub-center and every corner shop. If not do let us know. Contact.....*
- *"I have just married. I want to adjust and finish my studies and spend some happy time before we start looking after a child."*

Discuss which of these you think contribute to behaviour change – and which would be wasted effort. Which audience segment would you address each of these messages to.

BCC work will require good qualitiative work and/or understanding of specific constraints or current perceptions of people.

Demand for sterilisation in Gujrat

A year long campaign promoting the small family norm built around the slogan "we two, ours two" did not increase the demand for sterilisation services in a PHC in Gujarat. A study done from IIM Ahmedabad showed :

"Our survey results also revealed a sizable proportion of non acceptors of family planning. The annual target for sterilizations is around 350-375 per PHC. At one community served by a PHC, we estimated there were 1,176 couples who did not want more children but nevertheless had not accepted sterilization; this gap could be defined as unmet need. During our in-depth interviews, we probed the reasons for not accepting this method. Fear alone accounted for approximately 4 percent of the total unmet need for contraception. "Poor health" and the belief that sterilization caused weakness accounted, respectively, for nearly 22 percent and 18 percent of unmet need in two PHCs we studied. Underlying responses like these may be apprehension about the operation -apprehension caused by anecdotal information from clients about the poor quality of services."

Source: Dileep Mavalanker & Bharati Sharma, Quality of Care in Sterilisation Camps, IIM, Ahmedabad

Now a BCC campaign should be started focusing just on this point – that sterilisation does not cause weakness and addressing the apprehension about operation. Of course it would have to go along with improving the conditions of the operations – for the fear of the surgery was partly justified by the way it was being organised there.

In the promotion of contraception there is little point driving home a message without understanding whether it is lack of knowledge that is the real cause for non acceptance. If people have heard of it but not using it we need to understand why. Not dismiss it as irrational and keep plugging away. Consider people's responses as rational, find the causes and address it in a focused way.

Bcc and use of Comdoms

A multi-media campaign stating – "Be safe: Use condoms" for a year had no improvement in usage of condoms.

It was found from a qualitative study that that almost all women were aware of the condom and many wanted to use it. But though in that village, women were educated they were too embarrassed to talk to their husbands about using a condom. Indeed they never talked about sex at all. They just submitted silently when asked to. Men were too embarrassed to talk also – and to collect the condoms from the anganwadi worker who was of a different social status. The BCC campaign focussed on meeting women and men and focussed on the message- "do not be embarrassed to talk about it. Plan for it – it is the educated thing to do." The ANM also arranged for a joint counseling session where she got them to discuss what the problem in using the condoms was. This was the first time they had spoken to each other about it. A television spot was introduced showing a woman stopping the man gently and asking him – "did you remember to buy it. Oh you are more shy than me - I got it from the Anganwadi worker."

The next Lesson considers the various constraints in detail.

Male Participation on Population Control

This is not merely an issue of BCC, though BCC is the key to making it happen. There are also serious supply side constraints to why it does not happen. Thus though it is true that men are less willing to be sterilisation acceptors, the men who are willing are often unable to access the same service easily. In many districts it is easier to access female sterilisation rather than male sterilisation despite the latter being technically much easier to deliver. Male participation involves the following:

a. Male acceptance of sterilisation preferentially to the woman because it is inherently safer.
b. Male initiative based temporary methods, that is the use of condom, in preference to female based methods IUD and pills which have more side effects.
c. Male presence during counseling sessions so that better quality decisions are made and the women's needs are articulated better – as sometimes she may be unable to make decisions effectively without his participation
d. Male support during pregnancy, child birth and child care.
e. Male attitude to resist early age of marriage and keep daughters in school longer.

Planning for Efficient Provision of Contraceptive Services

This is covered in the Lesson 8.

I. Review Questions

1. What are TFR, NRR and CPR?
2. What is the problem with targeted sterilisation approach? Why was it given up?
3. What are the proximate determinants of high fertility? How do we address them in the district plan?
4. What is the difference in a plan where CNA shows that the total unmet need is near to the total service required to meet the FP programme goals as different from a district where the demand for services is far short of the total requirement.
5. What were the problems with BCC for the family planning programme. How do we need to plan BCC programmes to support the FP programme?

II. Application Questions

1. We said poverty is a determinant of large family size. But there are no measures in the district health plan to address poverty. Do you think they should be there? What could they be? Discuss.
2. Addressing the issue of gender equity is essential for rapid fertility reduction and ultimately in population stabilisation. Discuss.
3. How would it be possible to improve male participation in population stabilisation in your area? Discuss.

III. Project Work

1. What is the crude birth rate in the district? By the DLHS survey? By any other source?
2. What would be your plan for all components of population stabilisation – other than access to contraceptives ?

Lesson SIX

Promoting Contraception : The Technical-Managerial Interface

In this lesson we shall discuss:

- Why contraception is needed
- The main contraceptive methods available
- Constraints in providing sterilisation services
- Main constraints in promoting IUDs
- Main constraints in promoting pills and condoms
- What social marketing is and its strengths, cautions and limitations
- How to integrate social marketing into a district plan.
- Strengths and limitations of the public distribution system for contraceptives.

WHAT IS FAMILY PLANNING?

Having the number of children a couple want, when they want them, is called family planning. If you decide to wait to have children, you can choose one of the many methods of preventing pregnancy after sexual intercourse and these are called **contraceptives**.

"It is estimated that 100,000 maternal deaths in the world could be avoided each year if all women who said they want no more children were able to aviod subsequent pregnancies."

MANY OF THE PREGNANCY RELATED DEATHS OCCUR BECAUSE THE PREGNANCIES ARE:

Too soon: Mortality is higher in mothers age below 18. Infant mortality is also higher in such births.

Too late: After the age of 35 there are more complications in child birth, especially if the women have had multiple births before this.

Too close: A gap of less than two years increases maternal and infant mortality considerably. Even the elder children are affected due to inadequate child care

Too many: A woman with more than 4 children has a much higher chance of death during pregnancy and child birth.

Contraceptives help to delay the first child as well as ensuring enough of an age interval between two children. They also help to limit the family size to the desired level.

Other than saving lives family planning helps because :

- Mothers and babies are healthier because unwanted pregnancies are avoided or postponed.
- It allows for a happier family life including sexual life because the fear of pregnancy is removed and there is more time for the newly married couple to adjust.
- It helps couples, but especially women to complete their education and contribute better to social life.
- It means that resources and access to food are more available for each child.

Contraceptives provide a safe and effective way to regulate fertility and preserve health. A variety of methods are available: permanent and reversible, long-acting and short-acting. Methods are available for both women and men. When used properly and consistently, contraceptives can provide substantial protection against pregnancy. In addition to their effectiveness in preventing pregnancy, some contraceptives also have substantial non-contraceptive health benefits.

See Annexure 3 for a detailed description of contraceptive methods.

MAIN CONSTRAINTS IN STERILISATION SERVICES

Today demand for sterilisation services is much improved. The problem is in supply. There are problems of:

a) Availability of surgeons or gynecologists.
b) Availability of trained surgeons or gynecologists,
c) Availability of laparoscopes.
d) Availability of medical officers trained in mini laporotomy- conventional tubectomy.
e) Legal issues arising out of deaths and failure of sterilisation.

To understand this let us see examine a specific scenario:

In a block of one lakh population-approximately 2500 births would have taken place the last year (assuming birth rate of 25 per 1000). Of these about one thirds would be the first child, about one thirds would be the second child birth and about one thirds would be the third or higher order child birth.

We would expect that the entire last category and at least half of the second category come in for sterilisation. That would be 1200 potential couples who require sterilisation. If there is a back-log, and there usually is, the numbers are even larger.

The Supreme Court has fixed a ceiling of 20 cases of sterilisation to be taken up in a day. If we assume that each case takes 15 minutes – which is a good speed - 20 cases would take five to six hours – which is about the time that a surgeon should spend on operating. Beyond this, errors are likely to be common place. Some surgeons may contest this – but anyway there is a court ruling – and there are many consideration behind such a ceiling. Thus a case load of 1200 cases in a year implies at least 60 operating days in a year. At least about one day a week with more days on some weeks.

Hence the requirement for a **Fixed Day of the Week Sterilisation**. This fixed day approach means the ANMs and other health workers can inform the public that in any week if they come on that day of the week they could get their services – and even give appointments for that particular week.

However, the current scenario is that in a block, a camp is announced on just about 2 to 3 days in a year – almost nowhere are they held for more than 6 to 8 days in the year. The surgeon comes – has a huge queue waiting despite the fact that most women have received notice at the last minute and does as much as he can – hoping that the legal system does not take notice. Though no longer can they do 100 to 200 cases per day as they did earlier – usually they would go up to 50 to 60 cases and leave.

director of nursing or even deputy director – and it is often a male doctor who is assigned to be in charge of nursing. This workforce of many lakhs of women is held responsible for achieving all the main targets of health care such as reductions of MMR and IMR, but hold the lowest paid jobs with the least social or job security or respect in the hierarchy of health functionaries.

CASE STUDY: CHANGING COMPOSITION OF THE HEALTH WORKER

Sub-centers in all states were designed to have a male worker and a female worker. Over time, the only effective worker was the female worker or the ANM. Male posts were often not filled and this was justified by the fact that the center supported only the female worker who had family planning related functions while the male worker who had none was not supported. The male worker came to be seen as tending to laze around, unionise and not work. In many states unwritten policy decisions were taken to declare this a dying cadre and stop recruitment of the male worker as policy. In some states, in a bid to do away with this cadre on the grounds of their ineffectiveness, the male workers were all promoted as supervisors over the women who, however, did not get promotion. Net result – ANMs in most Sub-centers are handling double the load of what they were intended to handle and supervised often by male workers who have little understanding of the work.

If we ask a male workers' representative whether the charge of poor work justifies their exclusion, they had this to say: *"there have been no training programmes for male workers for over 15 years. Our work is poorly defined and often only seen as carrying the equipment and escorting the women workers. There is very little supervision or monitoring of the work – though ANMs work gets considerable attention. When an ANM is promoted she is given six months of residential training. But when a male worker is promoted, he has no training at all. For a number of years there has been no recruitment of male workers and in most states male worker pre-service training institutions have been closed down so that it cannot start either".* If we look closer we find that from the nature of funding to the nature of monitoring the real problem is the loss of importance to all work except some aspects of care in pregnancy and to immunisation. We can see that it is not a question of men versus women- both men and women are having to face a burden- though of different sorts. It is a question of how decision making and policy is "gendered"

3. **Women in community-based intervention strategies:** In community participation strategies, there is a prioritisation of women for undertaking health care responsibilities. This tends to further increase women's workloads and reinforce their traditional roles as care givers, without addressing the issue of male responsibility in health issues. Women are considered repositories of health related skills and information in communities and perform many informal health care functions. However, though this is utilised, this is poorly acknowledged and rewarded.

4. **Women in health sector research:** Women are not consulted in the formulation of their health needs and priorities – it is considered that society (which is a patriarchal society) knows best. Often, data that is gathered as a basis for determining the status of health is not disaggregated by sex at all. Obviously, the patriarchal basis for health care policy, research and programme affects the

CASE STUDY

Here is what one capable BMO did : He announced a family planning clinic on every Thursday of the month. On that day the following services were provided:

a) counseling by a trained nurse and male worker to every contraceptive seeker and indeed all men and women in the eligible age group who came on that day.
b) safe abortion services for those who wanted it. Diagnostics were done on that day (pregnancy diagnostic test, Blood pressure, urine for sugar, and blood for hemoglobin) and they were posted for the procedure - usually on the same Friday.
c) Vasectomy same day for those who wanted it.
d) Conventional tubectomy. Diagnostics on that day (pregnancy diagnostic test if they were not sure whether the woman was pregnant, blood pressure, urine for sugar, blood for hemoglobin) and surgery on the same Saturday.
e) Three months in a year a laparoscopic surgeon would visit twice a month and during these six camps he used to catch up with the demand.
f) There was a private clinic in the town in the neighbouring block who were willing to undertake laparoscopic sterilisation. And those who wanted only laparoscopy and were not willing to wait a whole year for it were referred there. The clinic would charge about Rs 700 to 1000 for it and were willing to take on a limited load of only 5 or six cases per week , as their main earnings came from other patients.

He estimated that he could organise 500 cases of vasectomy in a year– about 10 per week, another 500 cases of conventional tubectomy – average of about 10 per week and another 200 laparoscopic tubectomies in 4 to 10 camps in the last three months. when the laparoscopic surgeon(s) would be available for the district he could meet the entire demand.

Since there were four medical officers in the CHC and four in the four PHCs under him he had the only woman doctor and one male doctor trained in conventional tubectomy. He was himself trained in vasectomy; he got all the eight of them trained under his supervison.

Thus he could ensure that at least one trained doctor was available on the fixed day for all weeks of the year – even if some of them were on leave. Since the dates were well known, the ANMs, Mitanins, anganwadi workers could all help and bring in cases. Each of them would meet each of the families and explain the choices to them and find out the most convenient week for them to come.

The only other BCC he did was to put up a poster: " If you want to get sterilisation done, or want to get to meet a nurse to know how to postpone your next child come to any government hospital on a Thursday. This he put up in every village – massing five posters together to create an effect.

This BMO, we record, was not noticed!!!

In a neighboring district a smart officer got a number of highly publicized visible laproscopic camps organized. He prevailed upon all neighboring towns and cities to send laproscopic surgeons- ringing up some of them personally. One or two he also persuaded to come from the private sector. Thanks to his dynamism he could get them all to come. In five months of intensive work he completed the task.

His achievement was duly recognized and all talked of him as an example of a smart officer!! A smart collector or state secretary who drives the system to achieve the year's target is just that —a smart guy!! For even doing this is very difficult. The competent professional administrator is one who can build a system by which this can be done. Predictably – year after year!! That is the challenge.

COMPLICATIONS IN STERILISATION

For legal issues there is an insurance policy in operation. This is because we know that even where good care is taken, one cannot avoid a few complications and even deaths.

The expected number of deaths are 5.5 to 2.2 death per 100,000 operations (GOI, MOHFW 1994) and other figure we are assuming a rate of 2 death per 100,000 operations there would be 74-86 deaths due to sterilisation every year.

The expected number of failures are 5 per 100 women sterilisation surgeries, and 0.15 to 0.1 per 100 vasectomies.

However, if a surgeon has a track record of a high number of complications or deaths, then we must not rest with just insurance payments but identify and address systemic issues, for instance is there a skill deficit? Or a problem of OT sterilisation? Or supplies? In fact, it is now a mandatory requirement that every death or complication be investigated and the report be filed so that systemic failures are identified early.

Problems of getting Conventional Tubectomy Organised

First and foremost, these require getting the requisite training in place. Any gynecologist would require only one or two weeks of training. Any medical officer with some experience of surgery could be trained in a week. For a medical officer who has no experience of surgery, a one month training where they do some 30 to 60 cases under supervision would be enough. But it is really the number of cases done independently but under supervision which is the measure of training. Training has to be conducted by qualified persons.

The second problem is of getting the necessary equipment and supplies in place. This is a relatively smaller problem and most programmes have the funds needed for this. It is only a question of logistics.

Legal issues also need to be addressed. This is as stated earlier. The use of conventional tubectomy is best if there is a doctor with necessary skills posted there- not on a camp basis. In which case one does fewer cases per day with much less chance of failure or deaths.

Problems of getting Vasectomy Organised

Again the main limitation is the skills. But these are easier to teach and unlike the training in sterilisation can be done in a camp. Thus there should be a policy of making every CHC and eventually every PHC have these skills in place. If training is decentralised to the district level this is possible.

Supplies could be a problem- but such a minor one that it really speaks very ill of the quality of managernent if even this cannot be organised.

The participation of women in decision making at all levels is thus a critical factor in health intervention for women. Such women's participation is needed in the way cadres are structured and administrative appointments are made. It also occurs because women's organisations and men and women who have been working for women's rights are invited to be part of the decision making process. It also happens when women's movements and representative organisations, raise these issues in public debate and build up popular opinion for forcing a change. Some of the historical shifts of strategy in 'gendered policies' are discussed in subsequent lessons on gender mainstreaming and on population stabilisation.. These were changes that came about through a combination of such processes.

Other than in policy making, gender sensitivity and awareness needs to be increased at all levels within the health system. This ranges from the need to sensitise the husbands of women health workers towards better understanding of the demands of the job and better support to their wives. to ensuring that nurses have promotional avenues, to all health care providers being sensitised to the entire gamut of women's health needs – going far beyond the traditional male concerns of care in pregnancy and family planning.

and child-rearing. Though her role in child bearing and child care is indeed natural – the failure to see the male role in child care, and the failure to recognise that other than this she has an equal right to develop her talents and to take part in all decision making, be it in the family or in society, has nothing natural about it. It was a creation of patriarchy.

Our society is no longer feudal. It no longer states that birth determines privilege and status. It is supposed to be based on equality of opportunity and merit. However in practice, even in today's society birth determines one's status and one's opportunities to a large extent. And today we study patriarchy and gender to understand the various mechanisms by which there continues to be so much inequality for women and injustice against women in a society which states equality and justice as basic constitutional values.

> *The roles of a woman in child bearing and child care are naturally well-recognised, but the failure to recognise the male role in child care or the failure to recognise that in addition to these, a woman has an equal right to develop her talents and to take part in all decision-making, has nothing natural about it!*

In particular in the field of health we need to understand why being born a woman makes for a much higher likelihood of disease or death up to the age of 30. Further we need to understand why most doctors, especially in the government system are men, whereas almost all nurses are women. Why the Sub-center had a female and male worker but now largely has only female workers. Or why health system gives so much attention to reproductive health and not to mental health even though suicides kill far more women than child-birth. Or why in most hospitals there are fewer beds for women and fewer toilets.

Gender should also be understood as a product of the relationships between men and women, as well as an attribute of men per se. Men benefit from but also 'suffer' social and cultural constructs of 'manliness' and how men should behave. For example, they are also expected to shoulder the economic responsibility of the family and failure to do so leads to tremendous loss of self-esteem - which in turn becomes a problem for earning women who are supporting husbands. (Though often women are also earning and this invisible role does not even get acknowledged.) In family life, what they gain in power and domination over women, they lose many times over in terms of companionship and support and indeed in the happiness and pleasure of life itself.

Nor should patriarchy be seen as merely the physical oppression of men by women. Patriarchy defines life patterns and culture, and even the way men and women think about one another. This includes the way women think about themselves and about other women. Older women treat younger women who

a. The woman should have a medical check up before beginning on it.
b. They must appreciate its risks and its benefits And the contra-indications to starting it.
c. They must appreciate the need to take it on schedule and never miss a single pill.
d. They must know what to do if they have missed a pill once, or twice or more times in the week.
e. They must know what to do if they recognise that they have had unprotected sex since they did not note that a pill had been missed.
f. They must know about side effects – which of these they can ignore, which they need to consult on and which calls for them to stop even without waiting for a consultation.
g. They must know where they can purchase or get it routinely at short notice.

As we note from the above – in managerial terms- it requires that a well skilled counselor is able to counsel couples adequately on this. This makes all the difference between success and failure. Who would counsel? How would they be trained? How would they access the eligible couples? How would this interaction be facilitated by BCC work at other levels? All of these are managerial questions. If the entire content of the above does not get through the chances are that its use would not take off. No surprise therefore when we read the statistics and find that use of temporary contraceptives lags behind and there is a huge gap between consumption and use and another gap between use and regular use.

The second problem with condoms and pills is access. In most villages they are not still easily available- even for a price. Add to this the issue of embarrassment even with peers and the way power and sexuality

The Context of Usage[1]

The choice of method of contraception varies according to the context and circumstances:

Delaying the first pregnancy:

First choice: Condoms. This has no side effects and it is safe and easy to use. However it needs considerable male cooperation and to be able to use a condom every time requires a high degree of understanding and planning. If by counseling the man is able to understand not only health considerations but also the need for "pleasure before pregnancy" as part of building a close emotional bonding and trust between husband and wife, such cooperation would be easier to secure. But this requires good counseling and good quality, well focused BCC. If one cannot consider a pregnancy at any costs – then there is case for choosing pills instead –for its effectiveness is higher.

Second choice: Pills: This has side effects and should be avoided. Also though there is no medical evidence the family remains concerned that it may be irreversible. Still if the woman is educated and confident, especially if she has to complete studies or there is lesser degree of male cooperation, or they are part of a larger family where it is difficult to get, keep, use and dispose of condoms without embarrassment- the pill may be the only choice. Many women would manage pills without any side effects and those who develop side effects can change over to condoms. Especially when one is delaying only for two years or so, the pill is reasonably safe if cautions are followed.

1. For details on the various contraceptive methods, including failure rates, advantages and disadvantages, refer to Annexure 3.

What cannot be used: IUDs cannot be used. They could introduce infection and are not recommended for a woman who has not been pregnant before. Obviously permanent methods cannot be considered. Emergency contraception can supplement condoms use if failure to use condoms is occasional and accidental. It cannot by itself be a method of contraception. One further reason why the condom is an acceptable method at this stage is because accidental pregnancy if it occurs is usually – though not always – acceptable to the couple who decide to go through with it.

In effect therefore it is helping the couple make one of two choices.

Spacing

First Choice: Condoms: The advantages and the disadvantages are the same as described for delaying the child. Plus the fact that the pill is a very poor option at this stage, makes one have to consider condoms more. In addition to the protection offered by breastfeeding, it should give a high degree of effectiveness.

Second Choice: IUDs: The advantage of this method is mainly that it requires no male cooperation whatsoever and he may not even have to know about it. Though, it is not advisable for the woman to take a unilateral decision, there are times when there is no cooperation on the part of the male and since it is her body that would pay the price she may make such a choice.

Also unlike condom, there is no special effort needed every time.

The problem with IUDs is that in a percentage of women there are so many side effects that it has to be removed – or the women would remove it themselves. Also it could get displaced. If a woman misses her periods while being on IUDs it becomes essential for her to seek and get good quality medical opinion.

Third Choice: Pill: In the first six months after delivery the pill should not be used as it interferes with lactation which is essential for the child. Even after six months it adversely effects lactation. However if the child is not being breast fed or if adequate weaning and food supplementation has started, if male cooperation is lacking or the use the IUD has too many side effects, then the pill remains the best option.

The role of abortion: Unfortunately because of the problems associated with securing cooperation women do get pregnant too soon after the first pregnancy. Very often the pregnancy is an accidental failure to use condoms or a failure of the condom. Or it may be due to missed pills. More often it was because no method was being used. In this context many women seek and get abortion done.

If the couple is not ready for the next pregnancy then abortion should not be denied them. However abortion is not a substitute to contraceptiion. It does take a considerable physical and mental toll – equivalent almost to a pregnancy. To many women there is also a high guilt association.

A general rule that many gynecologists follow is to allow abortion once, but if the couple comes back again then they counsel them to go through with the pregnancy and then along with child birth get them to adopt a permanent method.

Waiting for sterilisation

This is increasingly becoming a major context for usage of temporary methods. Here there is not a lot of difference between the three methods. And one can be decided based on side effects and acceptability. Since unlike in spacing and delaying one does not want to go through with an accidental pregnancy, the condom which is inherently a less reliable option may get a lower priority. In some families abortion under such circumstances would not be considered/permissible and the pressure would be to go through with the pregnancy – especially if it is a boy. Under such circumstances the probability of sex selective abortion also

WOMEN IN THE HEALTH SECTOR

Though the mortality and morbidity resulting from women's ill health is a cause of great concern, its roots in fundamental human rights violations is poorly accepted or acknowledged in the health sector.

1. **WOMEN IN HEALTH POLICY AND PROGRAMMES:** Reproductive health is one of the largest focus areas of the health sector in current years. Though there is a strong focus on women's health in the form of 'reproductive health', it is mostly seen as a way of improving the 'health of society' rather than a redressal of a gross injustice to women per se. Though it is a big need of women to have good quality reproductive health services, if these are not set within an overall understanding and sensitivity towards gender discrimination and women's rights, they tend to reinforce the notion of women as mothers and undermine the focus required for other types of morbidity such as infectious diseases and cancer and the specific requirements of women in these areas. Even within the basket of reproductive health services, issues such as infertility and cervical cancer are neglected since they are not perceived to further the overall goal of population stabilisation or family welfare.

   It should be understood that most laws, policies and programmes for women's right to health are largely influenced by the preponderance of men in policy making roles and that their influence predominates again in health research and allocations of resources for health. Therefore, any attempt to change systems and policies must necessarily use strategies that ensure and enable the participation of women in decision making at that level. While engendering health policy is a difficult enough task, ensuring their conversion to programme is even more difficult, since there is a tendency for them to 'evaporate' before they ever become concrete; a phenomenon ascribed to the inherently patriarchal nature of bureaucracies.[3]

2. **WOMEN AS HEALTH WORKERS:** Women not only form the largest focus for the health sector as clients, specially as pregnant women and mothers, but also the largest providers of healthcare services in the field as ANMs, AWWs and now ASHAs. Yet, their representation in decision making positions of authority remains very poor- even where it is made up of such a workforce. Thus no nurse can rise to be a

> The health sector can play a vital role in preventing violence against women, helping to identify abuse early, providing victims with the necessary treatment, and referring women to appropriate care. Health services must be places where women feel safe, are treated with respect, are not stigmatised, and where they can receive quality, informed support. A comprehensive health sector response to the problem is needed, in particular addressing the reluctance of abused women to seek help.
>
> *Source:* WHO Multi-country Study on Women's Health and Domestic Violence against Women, 2005

3. SH Longwe, The Evaporation of Policies for Women's Advancement, UN, 1995

Selection of Target Groups

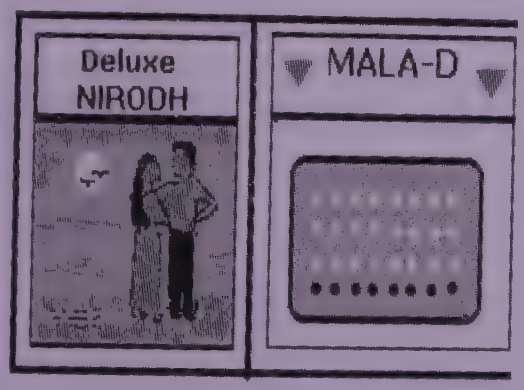
One of the first steps in marketing is to define the target groups for whom the services are offered and those who influence the service utilisation. The primary target audience are those whose behaviour or actions are desired to be changed. The secondary target audience are those who can influence the behaviour of the target.

Strategies

The four most widely used marketing tools are Product, Price, Place, Promotion.

(1) Product :

This could be a commodity, or could be a service. The concept has also been expanded to pushing ideas!! In order to have a viable product, people must first perceive that they have a genuine problem, and the product offering is a good solution for that problem. Research helps understand the consumer's perception of the problem and the product, and build a marketing strategy based on that.



(2) Price :

Social marketers balance different considerations, and often end up charging at least a nominal fee to increase perceptions of quality and to confer a sense of "dignity" to the transaction and keeping it well within affordability in relation to perceived value. These perceptions of costs and benefits can be determined through research, and used in positioning the product.

(3) Place :

"Place" describes the way in which the product reaches the consumer. For a tangible product like contraceptives. this refers to the distribution system-including the warehouse, trucks, sales force, and retail outlets where it is sold, or places where it is given out for free.

Another element of place is deciding how to ensure accessibility of the product. By determining the activities and habits of the target audience, as well as their experience and satisfaction with the existing delivery system, research can pinpoint the most ideal means of distribution for the offering.

There are three additional elements involved in the distribution of the social product.

Personnel (who delivers it), *Presentation* and *Process.*

(4) Promotion

The most important "P" of social marketing is promotion. Because of its visibility, this element is often mistaken as the fact comprising the whole of social marketing. However, as can be seen by the previous discussion, it is only one piece. Promotion consists of the integrated use of advertising, public relations, promotions, media advocacy, and personal selling and entertainment vehicles. The focus is on creating and sustaining demand for the product. Again a good understanding of what are the barriers to (a) perceiving this as a need, and (b) why is the need is perceived it does not translate into practice – is essential for designing a promotion strategy.

1962	• Introduction of Nirodh (unlubricated condom) for free distribution.
1968	• Social Marketing of Nirodh launched with 6 leading consumer goods/oil companies with 3 lakh outlets, with area allotted to each. (These were: Lipton, Brooke Bond, Union Carbide, Hindustan Lever, Indian Tobacco Company, Tata Oil Mills).
1977	• Introduction of Trade Bonus Scheme for retailers on purchase of condoms to encourage sale.
1983	• Introduction of promotional incentive on sale of condoms to SMOs instead of trade bonus on condoms.
1984, 1987	• Lubricated Nirodh added on seeing consumer preference and was named 'Deluxe Nirodh'.Later super deluxe nirodh added.
1987	• Oral Pills – the social marketing programme was extended to include Oral Contraceptive Pills with the brand name- Mala-D.
1988	• Voluntary Organizations included in SMP:eg: Parivar Sewa Sanstha introduced "Sawan" and "Bliss" under condom and "Ecroz" under Oral Pills. Population Services International introduced "Masti".
1993-95	• Larger number of organisations joined the programe and shift to "cafeteria approach". Large number of brands introduced by SMOs. For condoms: 'Zaroor', 'Mithun', 'Sawan', 'Bliss', 'Milan', 'Masti', 'Pick me', Mauj', 'Sangam', 'Ustad',and 'Ahsaas'. For oral pills, the major prevalent brands are Choice, Apsara, Ecroz, Pearl, Suvida, Arpan, and Sugam. Besides, these brands are allowed to be marketed by the SMOs on all India basis as against the Govt. brands (Deluxe Nirodh, Super Deluxe Nirodh and New Lubricated Nirodh) which are allowed to be marketed in the specified territories only.

Social Marketing in India

Source: Government of India (2001): *National Strategy For Social Marketing*, Department of Health and Family Welfare, Ministry of Health & Family Welfare, New Delhi.

Differences in Social and Commercial Marketing

Commercial marketing generally involves creation of demand for tangible merchandise with perceived immediate benefits for the consumer. Social marketing campaigns, on the other hand, promote products with long-range benefits and low baseline perception of utility.

Secondly, commercial marketing offers products which promise social acceptance, whereas, social marketing asks consumers to adopt behaviors which may challenge traditional practices.

Thirdly, factors affecting the price of social marketing products can also differ from commercial products.

Fourthly, with regard to promotion, social marketing entails a wider array of techniques: Interpersonal communication, including teaching of new practices has been cited as a critical and distinctive component of social marketing. Such a methodology has little place in commercial marketing, which relies almost exclusively on mass media.

In practice however, the line between the disciplines often becomes blurred as there are elements of each of these in both types of marketing.

Critique of Social Marketing

(A) Social Marketing is merely a commercial marketing approach, which is being incorporated into driving providers' priorities. They are not necessarily peoples needs- and are a 'social fix' a complement to 'medical fixes' for solving some health problems.

(B) Profit orientation of social marketing firms and accountability issues often lead to poor results – as one could slide into commercial marketing or merely collecting rent/subsidy from the government. Also because profit orientation is weak, often social marketing does not have the efficiency of commercial marketing leading to poor performance.

(C) Marketing projects, typically, are evaluated on sales and profit figures, i.e. how much/many condoms or packets of ORS were purchased at various distribution centers. The use of this criteria is ironic considering that, philosophically, social marketing is "for a social good", and its effectiveness might best be measured by that standard. In one study in Sri Lanka it was shown that high sales did not co-relate with better birth control. This can happen even here –where stocks could be sold by the social marketer quite well but there is no counseling available- leading to improper use.

(D) Social marketing can displace community participation. In social marketing projects attention is

typically focused upon institutionally determined health behaviors and products as opposed to identifying the priority health issues of the community. Community participation is noticeably absent in the vertical approach of social marketing. Through its mass media promotional campaigns, social marketing attempts to persuade an audience rather than engage them in critical evaluation of products or behavior, including those being advocated. In other words, one solution is promoted, but other possibilities are ignored. That is why social marketing is often accused of being manipulative. On the other social marketing seeks to understand indigenous concepts and to utilise them in presentation of new ideas or products; which often bureaucratic state run health education ignores.

(E) Another factor we need to note is that mass media messages, on which social marketing is based is poorly individualised, and therefore cannot be fine tuned to reach specific segments within a multiethnic community. In addition, those at the bottom; most in need of the product may have limited access to media sources or may not get enough information to use the socially marketed product properly.

Social Marketing and the District Health Plan

If the logic of social marketing of contraceptives is to simultaneously address behaviour change issues and supply side logistic issues to get the contraceptive to the user and ensure that he uses it – the point of attention of the district plan is to find out:

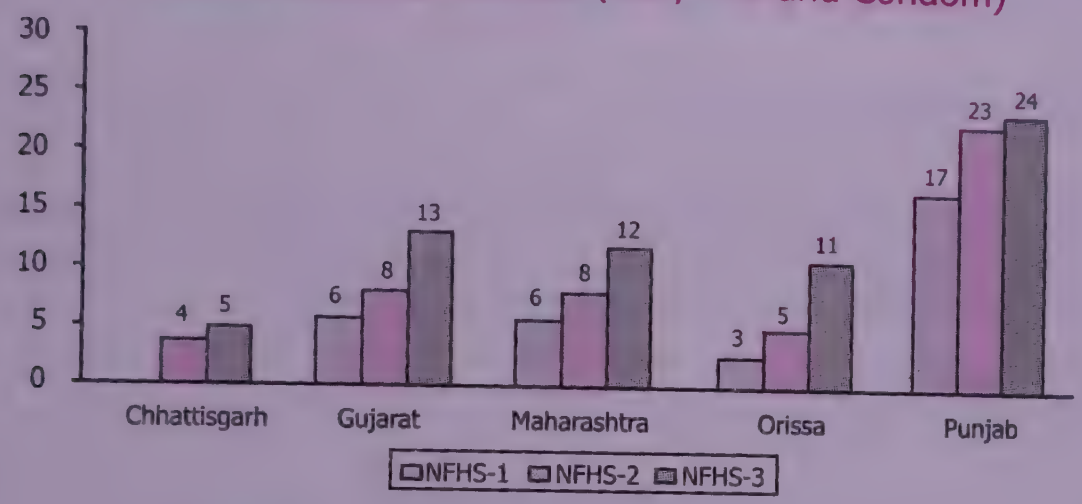
1. Whether indeed it is doing so? What are the areas where the contraceptives are reaching and being utilised ? What are the sections of society in which it is working? And what are the areas that it is getting left out? This can be found out from those already operating in social marketing in the district. And it can be supplemented from village studies and planning efforts.
2. Who are the parties – private or NGO who are available for social marketing- what is their experience, their skills and their potential outreach?
3. To what extent social marketing can be extended or made more effective?
   a. Can the improvement of the terms of contract with the social marketing agencies lead to an improvement in performance?
   b. Does the social marketing party require research inputs to improve its performance?
   c. And given the poor skills in the private sector, especially when it comes to managing rural markets- would management and technical marketing support be required? There may be criticism of this- for a firm should be hired for already having this ability. But such is the rural reality, that if the alternative is for the CHMO office to undertake social marketing it is perhaps far wiser to invest public money in improving private sector skills- then over load the district health administration outside its area of core competence.
4. Or should we supplement or even replace social marketing with systems of public distribution linked to improved community participation.

These four decisions are to be made ideally at the district level.

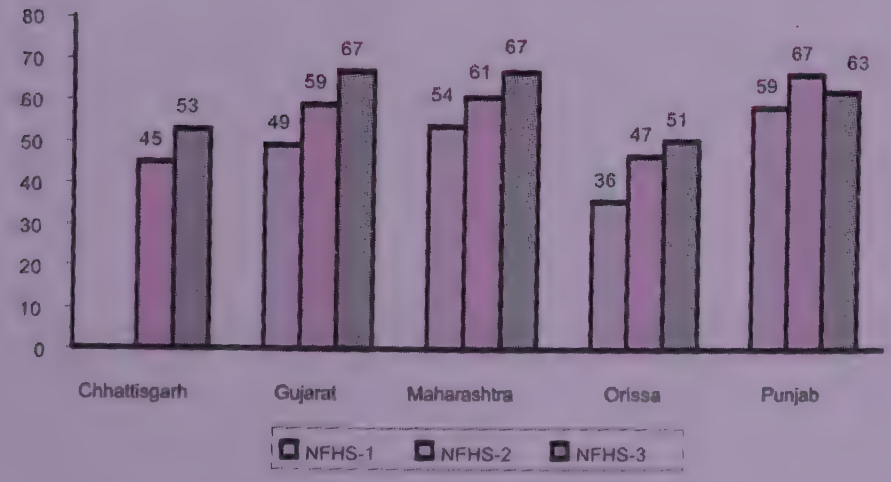
To understand let us compare the utilisation of temporary contraceptives in Gujarat with that in Chhattisgarh. We will assume a reasonably equivalent level of health sector performance – after all Chhattisgarh has dramatically reduced its infant mortality rate whereas Gujarat is relatively stagnant.

Trend in Contraceptive Prevalence Rate

Modern Spacing Methods (IUD, Pills and Condom)



Trend in Contraceptive Prevalence Rate



Sterilisation

Why does Chhattisgarh show almost a base line situation in temporary contraceptive use compared to Gujarat and Punjab whereas in sterilisation its figures are comparable. Could it be that Chhattisgarh has much less social marketing firms in operation. And if so why have they not come to Chhattisgarh?(actually they have come but have not expanded much) Does it relate to the degree of urbanisation these states have had? How can social marketing be promoted in a largely tribal rural state where considerable part of the economy is outside the market- and marginalised as far as market mechanisms go? Or is it that when market penetration in Chhattisgarh is low we have to look for public distribution options- backed by the much more active community participation that is available in Chhattisgarh?

If this is the situation between states – the difference between districts within the states can be even more skewed. There are districts in Chhattisgarh which may have a greater market influence than the more backward districts of Punjab or Gujarat. Unless we know what the situation is a common plan for the state is unlikely to be the most efficient way of achieving the objectives. This is really the scope of the district plan and in an area like social marketing , it is essential to plan at the level of the district. In most situations we need to get a right mix of social marketing and public distribution in place.

PUBLIC DISTRIBUTION OF CONTRACEPTIVES

Here the health system itself arranges to deliver the contraceptives through its network of public facilities. Usually the contraceptives travel from district stores , to block level stores to the primary health centers and from there to the sub-centers. The health workers in the sub-centers distribute the stocks to the community health worker or depot holder or anganwadi Kendra and replenish stocks once they are used up. Each of these facilities can also deliver directly to the users who come to it.

The staff at the facility and at the stock holders in the community also act as promoters of its usage and also serve for purposes of counseling and advice. To the extent that the community is aware of its needs and makes it choices it would then avail of these services. However the weakest link in the free public distribution of services is that in the absence of any financial indicator- it is quite difficult to get the **logistics** right. So we have a situation where there is considerable unmet need in the community while stocks are being buried quietly because of crossing the expiry date.

WHAT DO WE MEAN BY LOGISTICS?

Logistic is a vitally important part of any product distribution system of a mass consumption commodity. With reference to contraceptives, it is the system that is responsible for getting the contraceptive from the manufacturer to the client using the family planning method. It encompasses a number of activities along the way, such as transporting and storing the contraceptives, maintaining adequate supply levels, and keeping records. The success of the system depend upon the "logistics" and if it is not working well, it will not have the contraceptive supplies their clients need. The purpose of a contraceptive logistics system is to get the right ***quantities*** of the right ***contraceptives*** to the right ***place*** at the right ***time*** in the right ***condition*** at the right ***cost.*** In other words the manager who is managing the contraceptive supplies needs to determine ***how much*** (quantity and cost) of ***what*** (contraceptive) needs to go ***where*** (what location) ***when*** and ***how*** to get it there in good condition

For this the manager who is in charge of managing contraceptive supplies in the district needs to know the service delivery sites and the intermediate stores through which the supplies have to reach these sites, the stock on hand & rate of consumption of each product at each intermediate store. The district

warehouse will have to have a knowledge of every depot location – or at least the next hierarchy of stores and should have determined for each store and for itself the Maximum and Minimum Stock level along with quality, unit of packing and date of Manufacture and Expiry. Further he would need to know the quantities required, received and issued as well as the loss and balance in stocks.

These cannot and need not be built up only for contraceptives. It would be part of efficient district warehouse and supplies management- and is covered in module 11.

In a district plan for public distribution, though knowledge of requirements in the field and community participation in promoting its use is important – where the system usually gives way is not in these aspects but in this logistics management. (Social Marketings strengths are not so much in health promotion but in precisely this issue but where social marketing does not work, or even if it works public distribution systems would need to be strengthened to reach those that the market inherently cannot reach) cannot understand.

References for Social marketing:

1. Department of Health and Family Welfare, Government of India, National Strategy for Social Marketing, Draft, November 2001,
2. Kotler Philip, Health Care Marketing, Third Edition
3. Kotler Philips, Marketing Management, Tenth Edition
4. Kotler P and Andresen A, Strategy marketing for non-profit organisation,1996

Review Questions

1. What are the forms of contraception that are most frequently used.
2. What are the problems being faced in getting tubectomy services organized.
3. What are the preferred options for delaying the first child as compared to spacing ? Why do the choices differ.
4. What is meant by social marketing and how does it differ from commercial marketing. What are the main weakness of social marketing.
5. What is the main weakness of using public distribution to reach temporary contraceptives to the public.

Application Questions

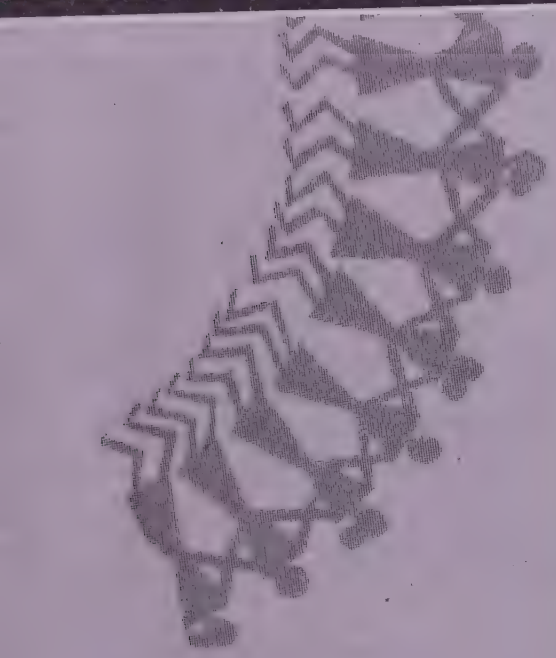
1. What are the determinants of readiness to use temporary contraceptives as compared to permanent sterilisation? Would you consider it appropriate that a family choose only temporary contraceptives throughout the reproductive age? Under what circumstances.
2. Would NGOs take up social marketing? Or should they stick to service delivery and advocacy?

Project Work

1. Suggest a plan for having fixed day per week sterilisation in every CHC and district hospital in the district within the next five years assuming that we have no more than two gynecologists both of whom are posted in the district hospital.
2. Who are the social marketing firms operational in the district? If you were to achieve a right mix of social marketing and public distribution of contraceptives what would be the district plan?

Lesson SEVEN

Adolescent Health



In this lesson we shall discuss:

- Reasons why need to have a separate focus on this age group
- The main aspects on which adolescent health care focuses
- Content of communication and service delivery
- Approach to communication and service delivery

INTRODUCTION

The 11 to 19 year old age is called adolescence. This is the period of rapid change and maturation when the child grows into an adult.

This is also the phase of second growth spurt in a person's life cycle and the last chance to make up for any growth lag that has occurred earlier. This is one of the most enjoyable stages of one's life and it has to be experienced with joy and friendship, paving the way for building a healthy society with good social relationships. This in turn leads to a reduction of violence and suicides in that society. Adolescents constitute 22% of the country's population.

POLICY FRAMEWORK FOR ADOLESCENT CARE

There were three key policy statements that envisaged adolescents as a separate category in our country:

a. The National Population Policy 2000 identified adolescents as an under–served group for which health needs and within this reproductive and sexual health interventions are to be designed.

b. The National Youth Policy 2003 recognises 13 to 19 years as a distinct age group which had to be covered by special programmes in all sectors including health.

c. The National Curriculum Framework 2005 for School Education explicitly highlights the need for integrating adolescent reproductive and sexual health messages into school curriculum. Based on this the National Adolescence Education Programme of NACO along with the Ministry of Human Resources Development is developed.

Adolescent Reproductive and Sexual Health Programme (ARSH)

As part of the Reproductive and Child Health Programme which in turn is part of the National Rural Health Mission, the government has launched a programme called the Adolescent Reproductive and Sexual Health Programme. Why was such a programme, specifically aimed at adolescents, necessary? In what areas other than reproductive and sexual health do we need to focus on adolescents as a group? This focus on Adolescent Reproductive and Sexual Health (ARSH) and special interventions for adolescents was in anticipation of the following expected outcomes:

1. Delay age of marriage.
2. Reduce incidence of teenage pregnancies.
3. Meet unmet contraceptive needs.
4. Reduce the number of maternal deaths.

5. Reduce the incidence of sexually transmitted diseases.
6. Reduce the proportion of HIV positive cases in the 10-19 years age group.

In addition to these specific outcomes, the following are the general outcomes:

1. To ensure that full potential of growth and maturation is reached – physically, emotionally and socially thus adding to the social capital- the human resource of society. It is the next period of life as young adults when people are most productive- and adolescence is a preparation for it.
2. That high mortality due to suicides, accidents of young adults and increasingly of HIV, is reduced. Substance abuse/addictions are also reduced.

WHAT ARE COMMON ADOLESCENT HEALTH PROBLEMS?

One of the main problems during this phase of growth spurt is the inadequate calorie intake. Studies done with rural girls around Trivandrum[1] showed that they were taking a mean of 1355 K.Cals/day in the 13-15 years (early teenagers) and 1292 K.Cals/day in the 16-18 years (late teenagers) which is much less than recommended for the age groups. The commonly observed health problems as per the above sample survey were vaginal discharge (83%), hair lice (69%), headache (60%), painful menstruation (48%), irregular and excessive bleeding (46%), dental problems (44%) and short sight (22%). Silent urinary tract infection, poor menstrual hygiene are some other additional problems.

Psychological problems also arise like emotional disturbances (adolescence is a period of storm and stress), depression, low self esteem, anxiety over inadequate or excessive secondary sexual development etc.

Segmentation of Adolescents

1. The age group of adolescents can be further segmented into 10-14 year-old young adolescents and 15-19 year-old adolescents. 12% belong to the 10 to 14 age group and 10 percent belong to the 15 to 19 age group. Mortality in the 15 to 19 segment group is higher than in the 10 to 14 segment.
2. Females constitute 47 percent and males 53 percent of the population. Their problems over lap but there is sufficient difference to treat them as separate segments.
3. The 15 to 19 age group contributes to 19 percent of the total fertility rate of the country. This would imply that of the 15 to 19 age group a substantial part are married. Thus the 15 to 19 age group can be further segmented into married and unmarried.
4. In –school and out of school is another type of segmentation. An increasing number of adolescents nowadays are in school. This makes it easier to access them, but they are exposed to a different set of peer pressures.

1. Authors: MKC Nair and Ranjan Kumar Pejavar, Prism Books Pvt Ltd, Bangalore, 2000

Segmentation is important to planning strategies of communication and behaviour change and service delivery. The lack of segmentation has led to an almost complete failure to address the needs of the male adolescent. It also means that there is need for different set of messages and priorities between married and unmarried adolescents, between young in –school adolescents and out of school adolescents.

When we come to discussing strategies below, it is useful to keep this segmentation in mind and ask how the strategy is modified by the segment to which it is addressed.

Strategic Objectives to Address these Problems

1. Increasing Access to Information for Adolescents :

Ensuring for adolescents :access to information, counseling and services, including reproductive health services, that are affordable and accessible.

2. Improve Access to Nutrition :

This is a period of intense growth and last chance for catch up. No other time in life are as many calories and nutrients needed as in this stage. Lack of it leads to reduced growth and to increased susceptibility to infections. Further, improvements in health status of adolescent girls have an inter-generational impact. It reduces the risk of low birth weight and minimises neo-natal mortality. Low BMI in adolescence lead to low pre-pregnancy BMI which in turn determines the foetal growth and birth weight of the baby. Iron stores in the body during adolescence determines the pre-pregnancy iron level and is a significant factor for pregnancy outcomes. The causal linkages between anemia and low birth weight, high neonatal mortality and maternal mortality have been established.

3. Increase the age of marriage and avoid pregnancies in this entire age group :

In one North Indian state more than 55% of first-time pregnant women were below 18 years of age. This increases the suffering that women have been facing on account of early marriage. Increasing the age at marriage promotes gender equity and will promote higher retention of girls at schools, and is also likely to encourage their participation in the paid work force.

4. Make for easily accessible and adolescent –friendly service deliver :

There are a number of health problems and anxieties which adolescents need to access treatment for. Service delivery places are alien environments, with major diseases and not the place of choice for seeking information on sexuality, or concern about some worrying changes in appearance(acne for example), or anxieties regarding bodily function ranging from menstrual disorders to possible STDs. Clinics often "brush them aside" both because "such" problems are considered trivial by the health care provider because they tend to treat adolescents casually. Yet to the adolescent the health issues they are facing are serious and stressful; it is just that they are not always able to express themselves well and with confidence.

They are not seen as adults to be taken seriously by physicians who treat adults. At the same time, they are seen to be "too big" to be treated with tender care normally expressed by a Paediatrician.

5. Promoting Healthy Life Styles:

There are particular habits like addictions- ranging from tobacco to hard drugs- that male adolescents have high susceptibility to. There are also violent behaviour life styles that can attract them and they can be forced to. Irresponsible sexual behaviour needs to be avoided and a normal sexual life without anxieties within the social context needs to be promoted. Other adolescents, especially females may be confined to the homes, denied mobility and access to social interaction especially meeting with males – all of which is unhealthy. Health Promotion activities like opportunity for sports, for self-expression in art forms, for learning and intellectual development opportunities, for recreation etc are important aspects of adolescent health for both men and women. Women have far less access to any of the above opportunities.

6. Provide integrated intervention in specially disadvantaged or under-served groups:

In the urban slums, remote rural areas, border districts and among tribal populations.

Some of the specific strategies undertaken by various governments are:

1. Kishori Balika scheme under ICDS by Dept of Women and Child Development.

2. Weekly once 100mg Iron Folic Acid supplementation of all Adolescent girls through schools and Anganwadi centres in Andhra Pradesh.

3. Peer education and Life Skill development through Education Department in Tamil Nadu , Maharashtra, Karnataka, AP etc.

The key strategic principles of intervention are given below.

Increasing Access to Information for Adolescents

1. *Strengthen Health Facility Based Counseling:* There is need for a service for providing counseling for adolescents within the district hospital and the CHC. In Primary health Centres and Subcentres, too the skills to provide counseling, both to adolescents and also to newly weds (who may also be adolescents) must be available. Counseling is for promoting a healthy sexual relationship; better choice and use of contraception ; protection from sexual diseases, and assistance if there is violence or if there is any serious discord. Often marital discord is related to the dissatisfaction with the sexual relationship and needs to be probed carefully and provided guidance on by a skilled counselor. Other than sexual issues adolescents may be concerned about their appearances, may require dietary

advice, or may require assistance to decide on marriage with reference to health problems they have. and may have diseases that cause them anxieties. Usually Health Facility Based Counseling is organised in parallel with health clinics which provide service delivery. But this is not essential as the skills and even the health care providers may not be the same. The use of communication aids especially published material and electronic self learning material makes it easier.

2. *Strengthen educational institution level access*: An educational institution is one of the easiest places to access adolescents in large numbers to provide them access to information and communication for change. There are three main forms of access:

   a. Conduct of a regular programme of health education and awareness with focus on all the health and non health issues of adolescents. Thus many schools organise a 10 to 14 part *life skills education* course with one class on this every week for 14 weeks. Teachers who volunteer can be trained to impart these sessions or the school could invite suitable resource persons from outside.
   b. *Peer Educators*: Train two or three students per class who have a good understanding of adolescent health care issues... Their skills are publicised to the class along with the information that they shall keep the names in confidence. The peer educators continue to live and work and study with the other class mates- but they can now be informally consulted by others and on suitable occasions they can talk about key health issues.
   c. Use of Posters, Help lines, Internet websites to reach youth with key messages.

Retention in school itself is more than half the achievement and the single biggest guarantee of health. Thus many children never come into the 6th class – being stopped from school once they come of age. If they could go up to the 8th class, they reach the age of 14 or 15- at least the young adolescent period is covered.

As of date the goal of the government is to achieve universal elementary education – all girls reaching up to the 8th class. This needs to be revised upwards to all reaching the 10th class and later the 12th class. For every extra year of schooling girls get, their opportunities for sports, for intellectual development and for social development are so much more. The opportunity for health education including on ARSH is also more.

3. *Peer educator networks:* Though this is a good school based strategy, it is also one a key strategies to meet out of school, older adolescents and to meet adolescents , especially in marginalised groups like migrants, rag pickers and certain occupational categories, street children and even larger socially under privileged groups like the urban slums or in tribal areas.

4. *Help-lines, Internet:* This can reach out to some of the more educated adolescent to access information. The phone numbers for the help line or the web page on the internet not only needs to be created and maintained, it needs to be well publicised – so that many others can access it.

5. *Community Health Workers:* For many rural areas, this is still the only mechanism that can reach out to adolescents with much needed information.

What Information Adolescents need to Know

- Understanding of what are the normal changes in adolescence.
- Understanding of body physiology especially as regards reproductive system.
- Understanding dietary and nutritional needs.
- Understanding to build healthy friendships with members of the opposite sex and to feel good and confident of doing so – without relating it to sexual relationships.
- Understanding of what are normal, healthy sexual relationships.
- Understanding to cope with sexual desire – when social and personal circumstances do not allow for sexual relationships.
- Understanding to negotiate in sexual relationships – to ensure that sex is responsible, safe and at terms where the woman has equal control- without having to feel dirty or guilty about sexual relationships.
- Understanding how to protect oneself from violence and what to do when faced with it.
- Avenues for creative activity- especially group activity – sports, creative arts, learning etc.
- Avenues for developing vocational skills or earning livelihood.
- Understanding of sexually transmitted diseases and reproductive tract infections – how to prevent them and how to access cure.
- How to use contraception to plan when and how to have a child , and to increase the quality of sexual experience.
- Knowledge about schemes and programmes for adolescents.

Improve Access to Nutrition

This is the period in life when there is maximal need for nutrition. Also when daily requirements are maximal not only for calories but also for proteins, iron and calcium. In other words the quality of diet – and dietary variety -also needs to be the best. The major limiting factor in accessing this is poverty . The second factor is patriarchy when intra-family allocation reduced availability for the adolescent girl who needs this the most.

Understanding this, there are various government efforts to address this problem. For example the ICDS programme provides for a package of nutritional services to be made available. In practice few adolescents have been able to access this. There have also been special schemes to give 10 kilograms of grain every month to the underweight adolescent. This too has been slow to implement.

There are no quick solutions to this. This issue is dealt with in greater detail in the section on food and food security in Book 9.

Increasing the Age of Marriage and Avoiding Pregnancies

Preventing the marriage of girls below the legally permissible age of 18 should become a national concern. For example, in the month of January 2007 a week long "Increasing Age at Marriage Campaign" is to be undertaken in all 23 districts of Andhra Pradesh by Department of Family Welfare with involvement of prominent NGO networks. This reform of increasing the age of marriage started almost a century ago – but there are still many communities where child marriages are not seen as a shame or as a crime.

One needs to enforce the Child Marriage Restraint Act, 1976, to reduce the incidence of teenage pregnancies.

A more positive approach is to promote higher retention of girls at schools. This would also encourage their participation in the workforce.

Social Pressure to be brought on errant families and specific communities by women's groups and organisations.

In many communities, though marriage is early, the married girl is sent to her husband's house only later. This is somewhat preferable- and one can work on delaying the time when they send the girl and on protecting her from pregnancy. Delaying up to the age of 16 may be possible – but often delaying up to 18, if the girl is already married, is difficult to negotiate because the young couple itself may not be opposed to it. Protection from pregnancy is needed but it requires not only good counseling of both husband and wife, but also the consent of the husband's family. At any rate though this compromise may be a practical necessity –the stress should be on pushing the age of marriage beyond 18, preferably beyond 21. For there are reasons of women's autonomy and choice also- not only safe motherhood – to be considered.

Adolescent Friendly Service Delivery

The following major routes are suggested:

1. Sensitised Personnel in the Normal Facility.
   Advantages: Where staff are few and turnover of patients is low there is no use for separate clinics. But sensitisation and training for managing adolescent health issues is a must.

2. Special Adolescent Health Clinics.
   Where staff are available, or even where enough staff are not available but there are sufficient people attending the outpatient department one would require a special clinic so that counseling and services can be organised. Usually a once a week clinic- preferably an afternoon session would be adequate.

3. Special Clinics in rural areas and urban slums on announced dates.
   This is similar to the family awareness camps- or part of it – and is conducted by ANMs and MPWs with the help of community health workers.
   Special Clinics in Schools – under the name of health check-ups could play this role.

4. Special Approaches to meet marginalised sections:
   a. For example a tea shop with a room nearby could be used as a counseling center and service delivery room for some types of services by a peer educator.
   b. A recreation club which is a meeting place for youth can be a health corner.
   c. A common facility that women in some occupations use – could have a health room etc.

Promoting Health Life Styles

This is largely the function of the Department of Youth Affairs and there is scope for coordination with it.

Thus, for example, the government could combine a massive adolescent screening programme of girls for anemia with a sports competition for rural girls or a cultural programme for youth. Organising such events would be beyond the core competence of the Health Department by itself – but by combining forces with the Departments of Youth Affairs, Sports, Cultural Activities, Tourism, and Women and Child Department, Department of Labor, Municipal bodies etc – the Health Department could build in a number of activities that provide opportunities for youth to take part together. A health component , that has behaviour change communication, counseling and service delivery aspects could be built into these.

Adolescents in Marginalised Sections

Urban slums are some of the most problematic. The male youth are usually out of school, without a job, have no place to go, no creative work to do and are subject to peer pressures and role models of criminalisation, irresponsible sexual behaviour and addictions. Often they have formed gangs, not necessarily violent, and turned away from usual social discourse. They would need to be met and offered alternatives-in ways of thinking, in ways of spending time, in positively interacting with women, in role models and so on.

The female adolescents are in fear, often face harassment, have a complete lack of privacy, and also have to negotiate to survive – often succumbing to pressures for sex to do so.

A combination of peer educators and health care providers working in coordination with Youth Departments is the best way to address this section.

Within this group are double marginalised sections- migrant youth who have no home, adolescent girls

and children who have no adult protection, women who are single, occupations like rag-pickers, street children, pavement dwellers and commercial sex workers and sanitation workers who are stigmatised and face dangerous working conditions and so on. A large number of these sections are in their teens or young adults. Building up special programmes to meet these vulnerable sections is also urgently needed- recognising the basic principle of their human rights. There are examples of some Police Officers taking imaginative steps in this direction to reduce crime rate in their area. If not at least out of fear - for they are also hot beds for the production of deviant behaviour which can affect the entire social fabric.

Mainstream health planning has not been ever able to address such sections.

WHAT COULD BE FEATURING IN 'ADOLESCENT HEALTH INTERVENTIONS' IN A DISTRICT ACTION PLAN UNDER 'NATIONAL RURAL HEALTH MISSION'?

AWARENESS PROGRAMS FOR ALL STAKE HOLDERS

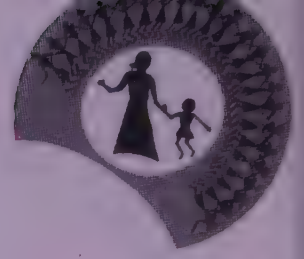
- Adolescents
- Parents
- Teachers
- Panchayath members
- ICDS workers
- Health workers
- Governmental agencies like; Kudumbasree, NYK, etc...
- NGOs
- Program managers
- Policy makers.

TRAINING PROGRAM FOR PROGRAM STAFF

- ICDS workers
- Health workers
- NGOs
- Doctors (Health service & Private sector)
- Program managers

SERVICES FOR ADOLESCENTS

- Family Life & Life Skill Education (below 18 years)
- Sexual & Reproductive Health Education (school & out of school)
- Pre-marital & Newly-wed counselling (Age 18 plus)
- Yearly Medical Check-up & Nutritional monitoring
- Immunization facilities (compulsory & optional vaccines)
- Use of Adolescent Health Card for monitoring
- Emergency medical services
- Emergency contraceptives & abortion services
- Counselling services (school & out of school)



Intervention Strategies & Steps

- Assessing data on Adolescent Sexual and Reproductive Health (ASRH) needs of adolescents in the country
- Review and preparation of Family Life Education (FLE) module
- Increasing knowledge and life skills (FLE) of Plus-2 school adolescents
- Increasing knowledge and life skills of out of school adolescents through National Literacy Mission
- Formation of anganwadi based Teen Clubs for out of school girls
- Formation of Nehru Yuka Kendra Sangathan (NYKS) Youth Clubs based Teen Clubs for out of school boys
- Establishing Adolescent Development Center (ADC) at NYKS affiliated Youth Development Centers
- Adolescent clinic at PHCs and small private clinics
- Adolescent Care Counselling Support Services (ACCESS) units at Taluk and small private hospitals
- ASRH clinics at district hospitals and major private hospitals
- Policy Advocacy

Teenage Care Clinic at PHCs

The Health Services Department in a unique position to establish Teenage Care Clinics all over India on all Saturdays, to begin with in selected PHCs where the service of a Lady Medical Officer is available. Health department has the experience of conducting under five clinics at PHCs in a period when childhood malnutrition was a major concern. The strength of this department lies in the following areas.

i) Availability of large network of PHCs all over India.
ii) Availability of JPHNs for community mobilization.
iii) Availability of Lady Medical Officers in Majority of PHCs.
iv) Availability of Lab support at PHCs.
v) Availability of Referral facilities at Taluk/District Hospitals.
vi) Availability of Teenagers on Saturday (School/College holiday)
vii) Availability of an apex national training centre, Child Development Centre, established with the primary objective of "Reduction of Childhood Disability through Reduction of Low Birth Weight through Reduction of Teenage Undernutrition".
viii) No additional financial commitment.
ix) Panchayats would volunteer local support.
x) Availability of Reproductive and Child Health program all over India.

Adolescent Health Card

See attachment of a sample card used by Child Development Centre, Trivandrum-Kerala

Review Questions

1. What is the adolescent age group? How is it segmented?
2. Why are exiting health services inadequate to reach them? What is the special need to make it adolescent-friendly?
3. What are the main types of information that adolescents seek?
4. How do we address the issue of delaying the age of marriage and first pregnancy?
5. What is counseling? How does it differ from mere health communication to the patient or advising the patient ?

Application Questions

1. Have you heard of adolescent health programmes reaching to the male? Which do you think is more in urgent need of counseling – adolescent males or females?
2. What are the places where adolescent youth congregate? Which of these lend themselves to be used for health messages – promotive or treatment?

Project Work

1. If there are any adolescent clinics running go visit them and write a description of them? Otherwise with the cooperation of a local health authority try to have a focal group discussion with a group of adolescents on their health problems. Use a trained nurse for help?
2. How would you plan to implement a number of the proposed strategies in a block? Which would you prioritise? What would it cost?

Annexure ONE

The Medical Termination Of Pregnancy Act, 1971 (Act No. 34 of 1971)

THE MEDICAL TERMINATION OF PREGNANCY AMENDMENT ACT, 2002 (No. 64 of 2002) (18th December 2002)

An Act to provide for the termination of certain pregnancies by registered Medical Practitioners and for matters connected therewith or incidental thereto.

Ministry of Health and Family Welfare
(Department of Family Welfare)

Notification

New Delhi, the 13th June, 2003

G.S.R. 485(E) - In exercise of powers conferred by section 6 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following rules, namely :-

Experience and training under clause (d) of Section 2:-

For the purpose of clause (d) of section (2), a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely;

(a) (a) In the case of a medical practitioner, who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;

(b) In the case of a medical practitioner, who is registered in a State Medical Register:-

(i) if he has completed six months of house surgency in gynaecology and obstetrics; or

(ii) unless the following facilities are provided therein, if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology ; or

(b) if he has assisted a registered medical practitioner in the performance of twenty-five cases of medical termination of pregnancy of which at least five have been performed independently, in a hospital established or maintained or a training institute approved for this purpose by the government.

(i) This training would enable the Registered Medical Practitioner (RMP) to do only 1st Trimester terminations (up to 12 weeks of gestation).

(ii) For terminations up to twenty weeks the experience or training as prescribed under sub rules (a), (b) and (d) shall apply .

(d) In case of a medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

5. Approval of a place, -

(1) (1) No place shall be approved under clause (b) of section 4, -

(i) (i) Unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and

(ii) (ii) Unless the following facilities are provided therein, namely: -

In case of first trimester, that is, up to 12 weeks of pregnancy:-

a gynecology examination/labour table, resuscitation and sterilization equipment, drugs and parental fluid, back up facilities for treatment of shock and facilities for transportation; and

in case of second trimester, that is, up to 20 weeks of pregnancy:-

(a) an operation table and instruments for performing abdominal or gynaecological surgery;

(b) anaesthetic equipment, resuscitation equipment and sterilization equipment;

(c) drugs and parental fluids for emergency use, notified by Government of India from time to time.

Annexure TWO

Health Specific Checklist for Gender Analysis and Planning at the PHC Level

I. Women as mothers (reproductive health)

1. provision of complete antenatal care including referral of women at high risk
2. safe delivery including referral and transport in case of complications
3. post natal care including breast feeding counseling, family planning advice and proper check up
4. is family planning an integrated part of MCH and is it a free choice?
5. is contraception offered to unmarried women and girls?
6. is induced abortion legally provided?
7. is treatment offered for infertility, STDs, malaria and support provided for AIDS patients?
8. are these services provided by trained women?

II. Women as producers

1. health problems due to heavy workload
2. health problems due to unprotected use of pesticides or other working conditions

III. Women as users of services

1. have women been consulted regarding the location and timing of activities?
2. are all services available daily or are there special days for different activities?
3. has any consideration been given to local disease patterns in women?
4. is there information on use of traditional forms of medicine for these?
5. is there any information of impact of user services on women?

IV. Women as health care practitioners

1. Training: basic, induction, in-service
2. within the family – are women being targeted for IEC activities? Should men be targeted also / instead?
3. as TBAs : is their local context taken into account?
4. as village / community health workers: selection, training, supervision and supplies
5. as health workers: realistic job descriptions, in service training, support from supervisory system, safety of female workers, protection from sexual harassment, child care needs, salary increments and job satisfaction.

V. Health Committees

1. are women included as members?
2. are health workers trained in how to involve women, form women's groups and support them.
3. influencing factors on formation and running of health committees to make them more women – friendly.

---

1. Adapted from Report of State level workshop on gender training, Danida-Tamil Nadu Area Health Care Project, May, 2000

Annexure THREE

Contraceptive Methods[1]

TEMPORARY CONTRACEPTIVE METHODS: BARRIER METHODS

The Common Method: Male Condom

Condoms are thin barriers made of latex, plastic, or natural membranes. They look like long, thin, deflated balloons. There are both male and female condoms. The male condom fits over a man's penis. Sexually-transmitted Diseases are a significant problem in many countries and can lead to pelvic inflammatory disease, infertility, and, in some cases, death. Although no contraceptive is 100 percent effective at preventing disease transmission, condoms can greatly reduce transmission of human immunodeficiency virus (HIV), the virus that causes AIDS and all other STDs. Both male and female condoms work by preventing sperm from entering the vagina and reaching an egg.

Failure Rate

The failure rate depends a lot on how carefully this condom is used.
As it is commonly used it is only somewhat effective for preventing pregnancy. It has been seen that 14 pregnancies may occur per 100 women in first year of use or one in 8 couples are likely to become pregnant. It is effective for preventing pregnancy when used correctly every time: 3 pregnancies per 100 women in first year of use (i.e. about 1 in every 33 couples is likely to face a failure. This is a high rate.)

Advantages

- Absolutely safe. No side effects- hormonal or others
- Ensures high degree of male cooperation.
- Protects against HIV/AIDS infection and STDs, as well as pregnancy, when used correctly with every act of sexual intercourse.
- Can be used soon after childbirth.
- By preventing premature ejaculation and by the context in which it is used it can enhance the sexual experience.

Disadvantages

- Requires high degree of cooperation between partners; impossible without adequate male cooperation.
- Relatively less protective ability: Due to missed occasions, due to occasional improper use or rupture etc
- Needs to be thought about and used every time.
- In poor crowded settings it could be difficult to buy, acquire, ask partner to use, put on, take off, or throw away.
- Latex condom may cause itching for few people who are allergic to latex.

1. This section is derived largely from Hatcher, Robert A. et al and Johns Hopkins Center for Communication Programme (2001): *The Essentials of Contraceptive Technology*, http://www.advocatesforyouth.org/youth/health/contraceptives/index.htm; and Hatcher, Robert A. et al (2004): *Contraceptive Technology*, 18th Edition, Ardent Media, New York.

- It has a reputation for decreasing the sensation of sexual pleasure during sex. This was to some extent true of the earlier cheaper non lubricated condoms. However used with understanding and counseling it could contribute to better pleasure in sex.
- Poor reputation: Many people connect condom with immoral sex, sex outside the marriage, or sex with prostitutes.

TEMPORARY CONTRACEPTIVE METHODS: OTHER BARRIER METHODS

Cervical Cap

The cervical cap is a small latex cup that a woman inserts into her vagina before sexual intercourse. The cervical cap fits snugly over the woman's cervix. It is smaller than the diaphragm and is used with spermicidal cream or jelly. The cervical cap works by blocking sperm from entering the uterus. Suction keeps the cap in place so sperm cannot enter the uterus (the womb). Women should obtain a new cap yearly.

Failure Rate

Among typical couples who initiate use of the cap before having a child, about 16% of women will experience an accidental pregnancy in the first year.

If the cervical cap is used consistently and correctly, about 9% percent of women will become pregnant.

Advantages

- The cervical cap is small and easy to carry. May be put in up to one hour before sex.
- It will work continuously for 48 hours.
- It does not matter how many times a couple has sex as long as she leaves it in at least six to eight hours after the last time she has sex.
- The male partner doesn't have to know that the woman is using it, and it can be used in settings of limited or no male cooperation.

Disadvantages

- A clinician has to be consulted to be able to determine the right size as well as learn how to use it
- It is difficult for some women to insert a cervical cap properly even after being taught.
- You must wash your hands with soap and water before putting in the cap.
- A woman has to remember to take it with her on vacations or trips.
- It increases a woman's risk for inflammation of the surface of the cervix. If left in too long, increases slightly a woman's risk for a very serious infection called toxic shock syndrome. Don't leave the cervical cap in for more than 48 hours.

- It may accidentally be placed onto the cervix improperly or may slip out of place during sex. After putting it in, a woman must check to be sure it is covering the opening of the uterus, called the cervix.
- Latex (rubber) may cause irritation or a woman may be allergic to it.
- Fresh spermicidal cream or jelly is needed each time the cap is used
- Not easily available.
- Higher failure rates.
- The cervical cap should not be used during menstruation.
- Not in much practice.

Female Condom

Female condoms are made of thin plastic called polyurethane and look like long, thin, deflated balloons. This is NOT latex. The condom is placed into the woman's vagina. It is open at one end and closed at the other. Both ends have a flexible ring used to keep the condom in the vagina.

Failure Rate

Among typical women use of Reality™condoms, about 21 % will experience an accidental pregnancy in the first year. If these condoms are used consistently and correctly, about 5 percent of women will still experience pregnancy.

Advantages

- "Female condoms give women more control and a sense of freedom."
- A woman doesn't need to see a clinician to get it. No prescription or fitting is needed.
- The condom can be put in several hours in advance of sexual intimacy.
- It is safe and fairly effective at preventing both pregnancy and infection like HIV/STDs.
- Any lubricant may be used with the female condom. It also comes with its own lubricant.
- It can be used by individuals who are allergic or sensitive to latex.
- Polyurethane transmits heat well. This may ensure the pleasure element in sex is enhanced.
- Requires less male cooperation. This is the only method that the woman can use that protects against HIV and STDs in a setting where there is no male cooperation.

Disadvantages

- This condom is large and some call it unattractive or odd looking.
- The condom could be used improperly especially if the man is not keen on cooperation.
- It is not available in as many stores as the male condom and may be hard to find.
- The female condom about three times more expensive than male condoms.
- Higher failure rates.

Spermicides

Spermicide is a chemical that kills sperm. It comes in different forms: foams, film, creams, jellies and suppositories. A woman inserts a spermicide deep into her vagina just before having sexual intercourse. Spermicides provide some pregnancy protection when used alone, but they are much more effective when used with another method, like the condom, diaphragm or cervical cap.

Failure Rate

- Low effectiveness for preventing pregnancy as commonly used- 26 pregnancies per 100 women in first year of use. (1 in every 4)
- Effective for preventing pregnancy when used correctly every time- 6 pregnancies per 100 women in first year of use (1 in every 17).

Advantages

- Spermicides give the woman control over use of a contraceptive.
- It is available over the counter without a visit to a clinician.
- It can be put into the vagina up to 20 minutes before sexual intercourse, but it is also effective immediately.
- Spermicides are safe, have no hormones and are immediately reversible
- They have no effect on breast milk.
- Need very little or no male cooperation

Disadvantages

- Spermicides can be irritating to the vagina, and some people feel that it is messy.
- It may not be protective against HIV/AIDS. To increase effectiveness, use condoms.
- It is embarrasing for women to apply and even to carry around the equipment and gel.
- High Failure Rate makes it a bad option for using alone.

Diaphragm

The diaphragm is a soft latex dome that a woman inserts into her vagina before sexual intercourse. It fits over her cervix and is held in place by her vaginal muscles. It always needs to be used with spermicidal cream or jelly. The diaphragm works by blocking the opening to the uterus so that sperm cannot enter.

Failure Rate

- Among typical couples who initiate use of the diaphragm, about 16 % of women will experience an accidental pregnancy in the first year.

- If the diaphragm is used consistently and correctly, about 6 % of women will experience pregnancy.

Advantages

- A diaphragm gives a woman fairly good control over contraception.
- It can be put in up to several hours in advance of sexual intercourse.
- Diaphragms are safe; there are no hormones and no side effects from hormones.

Disadvantages

- Very similar to the cervical cap.

In comparison to the male condom – all the other barrier methods of temporary contraception are difficult to use and/or less effective in providing protection against pregnancy or against STDs, and are costly and difficult to access. They all also need some degree of male participation – which if could be secured would possibly be adequate to get the male to use a condom in the first place.

Hence we will discuss only the male condom further as far as these barrier methods go.

HORMONAL METHODS

Common Method: Oral Contraceptives ("The Pill")

Birth control pills, often called "The Pill", are pills that a woman takes daily to prevent pregnancy. They are made of hormones similar to those found naturally in a woman's body. The Pill works by stopping ovulation (release of an egg) and by inhibiting the movement of sperm.

Failure Rate

Among typical couples who initiate use of combined pills about 8% of women will experience an accidental pregnancy in the first year. But if pills are used consistently and correctly, just 3 in 1,000 women will become pregnant.

Advantages

- Very effective when used correctly.
- No need of male cooperation, no need to do anything at time of sexual intercourse.
- Pills decrease a woman's risk for cancer of the ovaries and cancer of the lining of the uterus (endometrial cancer), Ovarian Cancer. Pills also lower a woman's chances of having benign breast masses, it has none of the risks of ectopic pregnancies or Pelvic Inflammatory Disease that the IUD has.

- Pills significantly decrease a woman's menstrual cramps and pain.
- Pills reduce menstrual blood loss and anemia.
- Pills reduce post menopausal symptoms.
- Pills can reduce prevalence of acne by up to two-thirds.
- Many women enjoy sex more when on pills because they know they won't get pregnant.
- Pills suppress endometriosis.
- Missed pills are easy to manage when one knows about it.

Disadvantages

- Need to be ideally prescribed by a clinician after a proper check up
- A woman must remember to take the pill every day. This can be really difficult for some women.
- Nausea and/or spotting are the two problems women may have the first month on pills.
- Missed periods or very light periods. Pills tend to make periods very short and scanty.
- Some women experience headaches, breast tenderness, depression or decreased enjoyment of sex.
- Not recommended for breast feeding women because they affect quality and quantity of milk.
- Serious complications such as blood clots are rare, but do occur.
- Cheap – especially if got from government supply but Pills can be fairly expensive when bought from the market.
- Use of pills is associated with a statistically higher risk of developing cervical dysplasia and cervical cancer. Pills users with dysplasia who also have HPV (human papillomavirus) have a 3-4 fold higher risk of developing cervical cancer.
- Pill users who smoke or have hypertension are at significantly higher risk of suffering a stroke, compared to other pill users. Pill users who smoke are also at significantly higher risk of a heart attack, compared to pill users who do not smoke and to other women.
- Pills do not protect from HIV/AIDS or other STIs. One needs to use a condom for added protection.

Missed Pills? Here's What to Do

Missed only 1 (white) hormonal pills?

1. Take the missed pills at once.
2. Take the next pill at the regular time. This may mean taking 2 pills on the same day or even 2 at the same time.
3. Take the rest of the pills as usual, once each day.

Missed 2 or more (white) hormonal pills in any 7 days?

1. Most important: for 7 days use condoms, spermicide or avoid sex.
2. Take a (White) hormonal pill at once.
3. Count how many (White) hormonal pills are left in the packet.

If 7 or more (White) hormonal pills left- Take all the rest off the pills as usual, one each day.

Or

If fewer than 7 (white) hormonal pills left?

Take the rest of the (white) hormonal pills as usual.

- Do not take any (Brown) reminder pills. Throw them away.
- Start a new pack on the next day after the last (White) hormonal pill. You may miss a period. This is okay.

Missed 1 or more of any (Brown) reminder pills?

1. Throw the missed pills away.
2. Take the rest of the pills as usual, one each day.
3. Start a new packet as usual on the next day.

Source: Hatcher, Robert A. et al and Johns Hopkins Center for Communication Programme (2001): *The Essentials of Contraceptive Technology*; 5.13.

Progestin-only Pills

Progestin-only pills contain just one hormone, a progestin. They work by making cervical mucus thicker so sperm cannot get to the egg, and by making the lining of the uterus thinner. Sometimes they stop ovulation (release of an egg). They reduce monthly blood loss and therefore help protect against anaemia and also have been reported to protect against some STDs and pelvic inflammatory disease. For some conditions, the protective effect remains even after the method is no longer being used.

Failure Rate

- Among typical couples who initiate the use of progestin-only pills about 1% of women will experience accidental pregnancy in the first year.
- But if these pills are used consistently and correctly, 0.5% women (1 in 200 women) will become pregnant. For increased protection, one could use condoms as well.

Advantages

- Can be used by nursing mothers starting 6 weeks after child birth. Quantity and quality of breast milk do not seem harmed.
- No estrogen side effects
- Can be very effective during breastfeeding and when taken at about the same time every day.
- May help prevent benign breast disease, endometrial and ovarian cancer, Pelvic Inflammatory disease.

Disadvantages

- Menstrual irregularity is the big problem with these. While the amount of blood lost is less, bleeding may be at irregular intervals and there may be spotting between periods.
- Progestin-only pills tend to make periods very short and scanty. A woman may go several months with no bleeding at all, and some women do not like this.
- A woman must remember to take a pill every single day or Pills get easily missed.

- Need medical advice to start using it.
- Some women using progestin-only pills gain weight or complain of feeling bloated. Regular exercise and attention to a nutritious diet can minimise or control weight gain.
- Some women using progestin-only pills experience increased symptoms of depression.
- Progestin-only pills do not protect from HIV/AIDS or other STIs. Use a condom for added protection.

OTHER HORMONAL CONTRACEPTIVES

Depo-Provera ("The Shot")

Depo Provera is a shot that a woman gets 4 times a year (every 12 weeks) to prevent pregnancy. It contains medicine that is like progesterone - a hormone that is naturally present in a woman's body. The shot works mainly by preventing the ovary from releasing an egg.

Failure Rate

3 pregnancies per 100 women in first year of use (1 in every 333) when injections are regualarly spaced 3 months apart.

Advantages

- Very effective.
- Privacy: no one else can tell that a woman is using it.
- Long term pregnancy prevention
- Does not interfere with sex.
- No daily pill taking.
- Can be used at any age.
- No estrogen hormone side effect.
- Helps to prevent endometrial cancer, uterine fibroids, ovarian cancer.
- other medical Advantages- Prevent iron deficiency, reduces the frequency of seizures, reduces sickle cell crises.

Disadvantages

- Common side effect- changes in menstrual bleeding.
- May cause weight gain (average 1-2 kg. per year)
- Delayed returned fertility.
- May cause headache, breast tenderness, moodiness, hair loss, nausea and acne.
- Irreversible during the period of effect

Contraceptive Patch (Norplant Implant) ("The Patch")

The contraceptive patch is a thin plastic patch contains progestin hormone released slowly - about the size of a matchstick - that a woman wears on her skin to prevent pregnancy at least for 5 years.. The patch contains hormones just like the ones in most birth control pills. It releases these hormones through the skin and into the bloodstream. Instead of taking a pill every day, a woman sticks on a new patch each week. The patch works mainly by preventing the ovary from releasing an egg.

Failure Rate

1 pregnancy per 100 women in first year of use (10 in every 1000). Over 5 years , 1.6 pregnancies per 100 women (1 in every 62)

Advantages

- Very effective, even in heavier woman.
- Long term pregnancy protection.
- Effective within 24 hours after insertion.
- Reversible after removal of implant.
- Rest advantages like other progestin pills.

Disadvantages

- Need skilled health care provider during application or implantation as well as at removal.
- Minor surgical procedure required.
- Medical side effects like progestin only pills.

Vaginal Contraceptive Ring ("The Ring")

The Ring is a small, flexible plastic ring - about 2 inches wide - that a woman places in her vagina each month to prevent pregnancy. The Ring contains hormones just like the ones in most birth control pills. It releases these hormones into a woman's body through her vagina. Instead of taking a pill every day, a woman puts in a new ring each month. The Ring works mainly by preventing the ovary from releasing an egg.

Emergency Contraception ("EC")

EC (sometimes called "the morning after pill") is a special dose of birth control pills that prevents pregnancy up to 5 days **after** unprotected sex. The sooner EC is taken, the more effective it is. EC is very safe. It is not an abortion pill. EC works mainly by preventing the ovary from releasing an egg.

Intrauterine Device (IUD)

The IUD is a small, T-shaped piece of flexible plastic that fits inside a woman's uterus to prevent pregnancy. There are 2 types of IUD's: copper and progestin (a hormone found in birth control pills). The copper IUD lasts 10 years and the progestin IUD lasts 5 years. IUDs work mainly by preventing fertilisation, and interfering with the sperm's ability to reach the egg.

Failure Rate

T Cu-380 IUD (widely available and last at least 10 years): Very effective: 0.6 to 0.8 pregnancies per 100 women in first year of use. (1 in every 125-170)

Advantages

- o Very effective.
- o Long lasting.
- o Little to remember
- o Can be inserted immediately after child birth.
- o No interaction with the other medicines.

Disadvantages

- o Longer and heavier menstrual bleeding.
- o Bleeding or spotting between periods.
- o More camps or pain during period.
- o Perforation with improper insertion.
- o Chances of Pelvic inflammatory Diseases may be increased.
- o Require trained health person .
- o The woman users have to check the position of IUD string from time to time.

NATURAL METHODS

Lactational Amenorrhoea Method

The Lactational Amenorrhoea Method (LAM) is the use of breast feeding as a temporary family planning method means related to breast feeding. LAM provides natural protection against the pregnancy. If the woman keeps breastfeeding very often, her protection from pregnancy may last longer than 6 months and perhaps as long as 9 or 12 months- LAM provides important benefits for nursing infants, it makes sure that the baby gets needed nutrients and protection from diseases provided by breast milk.

Failure Rate

- As commonly used, 2 pregnancies per 100 women in 6 months after childbirth. (1 in every 50).
- Very effective when used correctly and consistently – 0.5 pregnancies per 100 women in the first 6 months after child birth (1 in every 200)

Advantages

- Effectively prevents pregnancy for 6 months without any pills or other contraceptives.
- Encourages breast feeding.
- No supply required.
- No hormonal side effects.

Disadvantages

- Effectiveness after 6 month is not certain.
- No protection against STD/PID/HIV.

Safe Period, Cervical Mucus Methods

This is based on the principle that chances of conception are much reduced if sexual intercourse is avoided during the period around ovulation. The period around ovulation is estimated from studying the cervical mucus or the body temperature or just counting the days of menstruation.

However the menstrual cycle varies so much that it is difficult to predict. And the cervical mucus methods require high degree of awareness and counseling/training. They are therefore very unsafe methods to use alone- though they could be combined with other methods of barrier contraception usefully.

Paradoxically, estimating the time of ovulation is useful to know when a couple wants to have children as timing sexual intercourse to the time of ovulation with a few days abstinence before increases the chances of conception.

Failure Rate

High failure Rate as commonly used, but effective when correctly and consistently used.

PERMANENT METHODS

Female Sterilisation (Tubal Ligation)

Female sterilisation is a very effective, convenient form of permanent birth control for women or a couple who are sure that they will not want more children. This means it is not reversible. A tubal ligation is a minor surgical operation that blocks a woman's fallopian tubes (the tubes that carry the egg to the uterus). Female sterilisation works by blocking the egg from reaching sperm.

Failure Rate

- In the first year after the procedure : 0.5 pregnancies per 100 women (1 in every 200 women)
- Postpartum Tubal ligation (immediate after the child birth): one of the most effective female sterilisation technique. In the first year after the procedure 0.05 pregnancies per 100 women (1 in 2000 women)

Advantages

- Very effective, permanent, safe method.
- Nothing to remember.
- No known long-term side effect.

Disadvantages

- Usually painful at first.
- Internal bleeding or infection.
- Injury to internal organs.
- Risk of Anaesthesia.
- Reversible surgery is difficult and expensive and not available in most areas.
- Small but defnite risk of surgical failure – 1 in 200.

Procedures of Conventional Tubectomy

Laparoscopic Tubectomy- In this procedure a small incision is made just below the navel (Umblicus)
Mini-laparoscopic – In this procedure a small incision just above the pubic hair.

Male Sterilisation (vasectomy)

Vasectomy is a very effective and convenient form of permanent birth control for men who are sure that they will not want more children. This means it is not reversible. A vasectomy is a simple minor surgical

operation that blocks the tubes that carry sperm from a man's testes to his penis. Male sterilisation works by blocking the sperm from leaving the man's body. It is not castration as often gets confused with in public perception. It does not affect the testes. This method has no effect on sexual performance or sensation. It is fully effective only after at least 20 ejaculations or 3 months. It has only uncommon minor side effects like bleeding and infection. Reversible surgery also difficult and expensive and require skilled hand.

Now a new No scalpel Vasectomy (NSV) is using in many programmes, uses a small puncture instead of 1or 2 incisions in the scrotum. It has some advantages like less pain and bruising, reduces operating time and shorter recovery time.

Failure Rate

- As commonly used: 0.15 pregnancies per 100 men in the first year after the procedure (1 in every 700).
- More effective when used correctly: 0.1 pregnancies per 100 men in the first year after 20 ejaculation or 3 months. (1 in every 1000)

Acknowledgements

Editorial Coordination
Dr. T. Sundararaman, Dr. Vandana Prasad

PHRN Editorial Advisory Committee
Dr. T. Sundararaman, Dr. Vandana Prasad, Dr. K.R. Antony, Dr. Kumudha Aruldas, Dr. Madan Mohan Pradhan, Dr. V. K. Manchanda, Dr. Dileep Mavlankar, Mekhala Krishnamurthy, J.P. Misra, Dr. V.R. Muraleedharan, Dr. Rajani Ved Arya, Sarover Zaidi, Dr. Suranjeen Prasad, Dr. Nerges Mistry, Dr. Sanjay Gupta

Production Coordination
V. R. Raman, Abhijit Visaria

Networking Support Committee
V. R. Raman, Abhijit Visaria, Dr. Kamlesh Jain, Anuska Kalita, Rambir Sikarwar, Victor Soreng, Haldar Mahto, Farhad Ali, R. K. Rath, Biraj Patnaik, Rafay Khan, Dr. Sanjit Nayak, Dr. Ashis Das

Acknowledgements
There are many others who have contributed in various degrees through valuable suggestions and critical comments as well as by providing key reference material. While we are unable to name all of them here due to considerations of space, the editorial coordinators would like to acknowledge their contributions with many thanks!

Public Health Resource Network

A Programme of Sharing Technical Resources to Strengthen District Health Programmes

The PHRN is a civil society initiative to support district level public health practitioners.The core of the programme is a 12-18 month distance learning programme. This course is being organised as a partnership programme of a number of Government and Non-Governmental Organisations and resource centres.

The series will cover the following themes :

QUARTER 1	QUARTER 2
• Introduction to Public Health Systems • Reduction of Maternal Mortality • Accelerating Child Survival • Community Participation and Community Health Workers • Behaviour Change Communication and Training	• Mainstreaming Women's Health Concerns • Community Participation beyond Community Health Workers • Disease Control Programmes • Convergence • District Health Planning
QUARTER 3	**QUARTER 4**
• District Health Management • Public-Private Partnership • Legal Framework of Health Care • Issues of Governance and Health Sector Reform	**Optional Courses** • Tribal Health • Urban Health • Hospital Administration • Non-communicable diseases and Mental Health • Disaster and Epidemic Management

Public Health Resource Network
C/o State Health Resource Centre, Chhattisgarh
28, New Panchsheel Nagar, Near Katora Talab
Civil Lines, Raipur 492001, Chhattisgarh, INDIA

Tel: 91-771-2446466, 2236175 Telefax: 2236104
Email: phrn.course@gmail.com Web: www.shsrc.org